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MODERN
HOSPITAL

VOLUME 52

JANUARY 1939

NUMBER 1



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WITH pride we present this month a new department for hospital trustees (page 73). Read it carefully and then turn to the advertisement on page 131. Presumably you will want to take advantage of the opportunity offered for aiding your trustees to keep abreast of hospital developments of concern to them.

ANOTHER new section will be found on page 116 under the title of "Relaxatives." Try these at the end of a hard day.

THE first two of several articles on food clinics that will appear during the coming year are on pages 48 and 49. Here is set forth the place of a food clinic in a community general hospital and in a large group of teaching hospitals. Succeeding articles will give details regarding the actual operation of the food clinic from various points of view. Both administrators and dietitians will find them of value.

FOUR new members are welcomed on to the editorial board of your magazine this month. They represent fine hospital administration in several parts of the country. They are George Bugbee of Cleveland, Dr. A. J. Hockett of New Orleans, Abraham Oseroff of Pittsburgh and George Wood of Oakland, Calif.

ALERT administrators are already beginning to plan for their observance of National Hospital Day. Next month we present an article from the prize-winning observance of the Paradise Valley Sanatorium and Hospital, National City, Calif. Imagination and enthusiasm combined to give this hospital an observance that attracted attention in all Pacific Coast states.

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THERE is a new nursing law in New York State. Since other state legislatures often follow the New York example, this law becomes of interest to hospital administrators in all parts of the country. Next month John H. Hayes, president of the New York State Hospital Association, will outline the law and describe its effects on hospitals.

SKIPPING now to the Middle West we find the state of Missouri going ahead rapidly on a comprehensive and generous program for the care of mentally diseased patients. A careful survey of the scope of the problem and the probable future demands for hospital care of this type has been followed by an extensive building program. The major outlines of this program are to be given to *THE MODERN HOSPITAL* readers in a series of three articles starting next month. These articles are on the "must" reading list for all administrators of mental hospitals. They also contain much meat for administrators of general hospitals, since mental patients are increasingly served by general hospitals.

THE new department of hospital pharmacy will appear next month. The response to this innovation has been most generous. Already we have in our files a substantial number of excellent manuscripts for publication in this department and more are coming.

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Practical Organization of Staff

JOSEPH C. DOANE, M.D., views the medical staff setup in its various guises from an intricate specialty organization to the simplest departmental arrangement.

Time to Call a Halt

S. S. GOLDWATER, M.D., points out the danger of the health center program with its clinical specialism.

Hospital Has Own Scout Troop

The superintendent of Children's Hospital, Buffalo, N. Y., MOIR P. TANNER, tells of a scout troop that does its scouting entirely within the hospital walls.

New Areas of Voluntary Service

Stabilization of hospital income through hospital care insurance will enable institutions to use gifts from philanthropists for research, construction and talented personnel, states ABRAHAM OSEROFF, director of Montefiore Hospital, Pittsburgh.

Automatic Safeguard for Sterilizers

CARL W. WALTER, M.D., of the laboratory for surgical research, Harvard Medical School, describes a reliable control for sterilizers worked out at Peter Bent Brigham Hospital.

Let's Be Salesmen

Every employe can help the hospital to gain patronage and support, contends ADA BELLE MCCLEERY, superintendent, Evanston Hospital, Evanston, Ill.

Trustee Forum

Let's Work Together

DAVID B. SKILLMAN, attorney-at-law and chairman of the board of Easton Hospital, Easton, Pa., tells of the financial loss to hospitals through trustee apathy.

The Trustee Controls Quality

How many trustees actually know what devices and services exist in their own institution? R. C. BUERKI, M.D., director of study, Commission on Graduate Medical Education, asks the question.

Plant Operation

Dry Ice Oxygen Tent

DAVID J. COHN, director of the department of biochemistry, Michael Reese Hospital, Chicago, describes the principles involved in the new type of oxygen tent that this hospital is finding uniformly satisfactory, and economical as well.

New England's Gadget Round Table

Description of some of the devices featured at the last meeting of the New England Hospital Association, as put down by SIDNEY M. BERGMAN, assistant director, Beth Israel Hospital, Boston.

Housekeeping

A Housekeeper's View of Asepsis

Well-trained employes are far more essential in maintaining asepsis in the housekeeping department than are elaborate equipment and a large variety of preparations for cleaning, declares MARY W. NORTHROP, chief dietitian and housekeeper, King County Hospital System, Seattle.

Food Service

Self-Service for the Staff

The change from waitress service at St. Christopher's Hospital, Philadelphia, met with quick success, reports LILLIAN HACK, the dietitian.

Contacts for Stimulation

How can the hospital dietitian keep out of a rut? MARY E. SMITH, chief dietitian, Memorial Hospital, Houston, Tex., has numerous suggestions.

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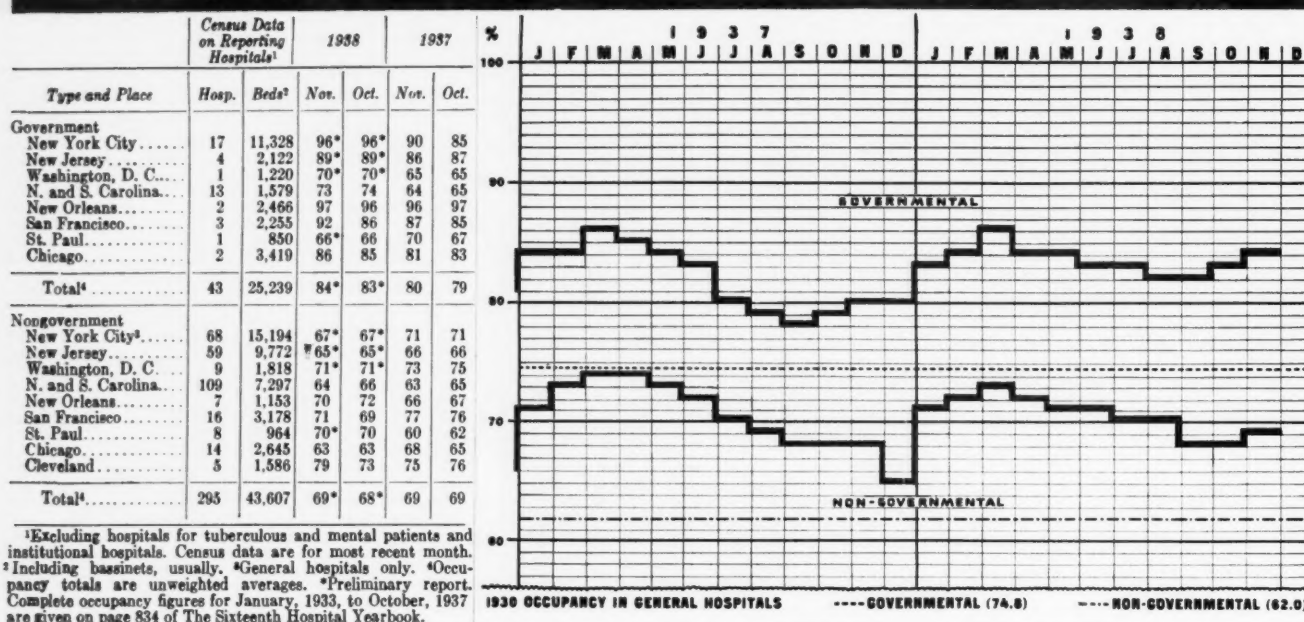
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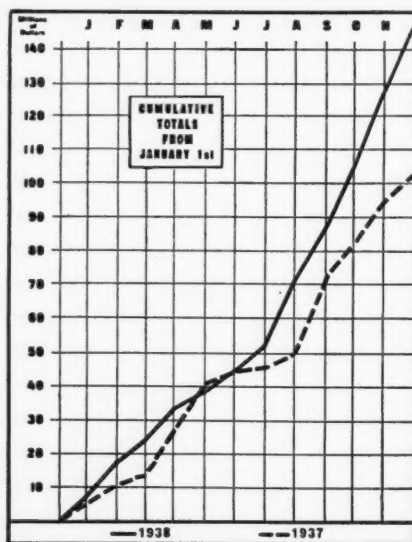
Year Breaks Post-Depression Construction Record

The year just closed witnessed nearly a 50 per cent increase in the value of new hospital building projects authorized. Nearly \$149,000,000 of new projects were started during the last twelve months (to December 19) as compared with \$103,500,000 for 1937. The 1936 figure was \$96,000,000; in 1935 it was \$41,000,000 and in 1934, only \$39,000,000. So 1938 constitutes the largest post-depression year by a wide margin. Most of the actual construction, of course, will not be completed until some time in 1939 as over \$60,000,000 was authorized in October, November and December.

Up-to-date figures on the number of beds added are not available at this time but it is doubtful if the increased construction has been sufficient to overcome the deficit piled up during the depression years when construction did not keep pace with growth of population, obsolescence of buildings and scientific advances in hospital service.

As usual the new construction announced during the past month (November 21 to December 19) was principally devoted to increasing the size and facilities of existing hospitals. Of the \$21,622,550 reported for the period by 64 reporting projects (5 additional projects did not give figures on

HOSPITAL CONSTRUCTION



cost), \$16,885,643 was to be devoted to additions in 52 hospitals. Nine of ten new hospitals reported costs of \$4,542,909. There was one alteration to cost \$30,000 and one nurses' home to cost \$165,000.

Hospital occupancy took a slight upturn in November, according to preliminary reports. In the voluntary general hospitals the November figure

rose from 68 to 69 per cent, thus equaling the figure for the preceding year. In governmental general hospitals, however, the occupancy rose from 83 to 84 per cent and thus maintained a four point advance over the figures for 1937. Since July the governmental hospitals have continued to have a higher occupancy than they had in 1937.

General business conditions looked decidedly brighter at the end of the year. The Christmas trade, as reported by leading department and mail-order stores, was ahead of 1937 in both volume and dollar value. The automobile industry appeared to be off to a good start on the 1939 models.

General wholesale prices as reported by the *New York Journal of Commerce* were down slightly in the period from November 21 to December 19, the index dropping from 75.6 to 74.7. Grain and building material prices advanced during the period, the former from 52.4 to 55.7 and the latter from 95.0 to 97.1. Food, textile and fuel prices all dropped, food going from 68.3 to 65.9, textiles from 54.6 to 53.6 and fuel from 83.0 to 82.1.

The price index for drugs and for fine chemicals remained almost unchanged at 182.7, according to the *Oil, Paint and Drug Reporter*.



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countered with old-style inhalators and have incorporated many new conveniences and safety features. Write today for folder No. C-255 giving complete details about the Colson Inhalator, Model NH-11.

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Model 4432, illustrated, with divided leg rests, is fully adjustable. Leg rests telescope from under the seat and adjust to any angle with it. Back is reclining, and with adjustable leg rests, chair can be converted into a comfortable bed. This model is available in three adult sizes—narrow, medium and wide. For complete specifications on all Colson wheel chair models, write for the Colson wheel chair catalog.



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ELYRIA, OHIO

WITH THE ROVING REPORTER

Parties in Paris

"All work and no play makes Jack a dull boy." My mistake! "All work and no play makes Jill a dull girl"; a poor nurse, too, which is even worse.

That's the way they look at things in Paris—Paris, Tex., if you please. Consider yourself fortunate if you happen to be passing through this little town, settled comfortably amidst the cotton fields, at a time when Margaret Kennedy and her associates are holding a hospital party. Who would think of passing through Paris anyway, without stopping at the Sanitarium of Paris to pay respects to Doctor McCuiston? Not your Roving Reporter. But that's another story.

Although it was still summer with the thermometer registering higher than any self-respecting thermometer should, there was talk of plans for fall parties, Halloween, Thanksgiving and such. "You can count on something original, if you'll only come back," they promised. It took will power to refuse. Texas hospitality isn't easily turned down, but we wouldn't be a Roving Reporter if we hadn't determined then and there to give you all the facts. A happy thought! Why not appoint a Roving Reporter who didn't rove but would promise to stand by and write a story on "Halloween in Paris"? Would Miss Kennedy take over the page for us, just this once? She would, and she has, like the gallant lady she is. No one can say, after reading it, that the choice was not a happy one.

It Was a Circus

"We collected posters that had been plastered all over the city for the real circus that had just pulled out. From these we obtained suggestions for a mock circus and later used them for our posters. The students added some ideas of their own, grouped themselves to carry out the various acts and performed their stunts according to their own notions. There were no formal rehearsals; each group practiced behind closed doors in order to present a surprise at the circus on Halloween.

"The list of acts to be presented was given to the chairman, who identified the acts by giving them the names of their directors: the Brownie band was directed by Gladys Brown; the Alleny

dog was trained by Marian Allen; Cleora, the Hawaiian board dancer, was Cleo Board; Virginia Hogan headed the Hogganian equestriennes. Programs were printed in order to facilitate an orderly presentation of the circus.

"It takes a stretch of imagination, perhaps, to visualize student nurses in the rôles of circus characters, especially when those characters include men and beasts. It also calls for good sized, well-lighted hospital grounds to accommodate a circus ring and an audience. The cost in money for such a setup is not much, but it is the jolliest place imaginable when the trees and rock walls hold jack-o-lanterns, witches' masks, owls and other Halloween symbols.

"There must be a movie camera man and a photographer with plenty of flood light bulbs, ladders and screens, for the circus parade should be recorded for the future. Too, a circle of chairs for the audience should be provided. Then, near the entrance to the circle, there must be cages for the cats, dogs and other live animals of the menagerie.

"It is 7:30 p.m. and an audience made up of hospital personnel, hospital visitors and the neighbors passes along beside the cages, mingles with the photographers and finds its place in the circle of chairs.

"Eight o'clock. The whistle blows. The parade, the grand preview, has started. It will pass in front of the movie camera and is headed by the ring master, who carries a whip and wears high boots and a long tailed coat.

"Behind the master comes the Brownie band in masks and natty uniforms. Toy trumpets blare, drums rattle, and the animals, following the band, go through their own characteristic paces. The gorilla affectionately nudges 'Frank Buck'; the Alleny dog noses its trainer. A man and his Persea lion cannot keep up with the parade. The Hogganian equestrienne steps before the camera and tips her white hat.

"Lady Mary's acrobats march in varied formations, while the Blank Indians do a few medicine dance steps before the camera. The airy fairy tight-rope walkers are accompanied by Cleora, the Hawaiian board dancer; Popeye and Olive Oyle follow.

"There is a clapping of hands as 'Frank Buck' enters the ring with his Stolzy gorilla on a leash. The gorilla is realistic in a big black fur robe, while Mr. Buck appears as good as the hunter he claims to be.

"The dog trainer provides real and instructive entertainment. She explains the art of animal training and, at the crack of her whip, a dog leaps into view, pushing a baby carriage in which a toy dog nestles. With words of encouragement from the trainer the dog plays nurse, jumps through a hoop and shows its teeth, and performs other dog tricks to the delight of its schoolmates.

"A janitor's truck is pushed into the arena. It brings a marvel. Here sits, crouches or lies a tun-shaped body, which when approached by its trainer, sends out a head and flutters its stumps of flaps. The baby monster writhes, tries to climb off its truck and, conscious of its inability to perform, utters a creaking roar that echoes beyond the ring. We are watching the performance of a so-called trained Persea lion, fitted into a black velvet skin.

Indian War Dances

"The Indian chief and his honest-to-goodness Indians, so far as appearances are concerned, approach with feathers, tomahawks, squaw and papoose. We hear war cries, witness Indian war dances and hand-to-hand combats.

"Then enter the 'Queens of the Air,' beautiful in regulation tight-rope attire. Before they launch into the intricacies of their act, they tread mincingly into the rosin and onto the rope, taut against the ground, slowly take a few steps forward, hesitatingly retreat and then tear into the breath taking stunts of reckless rope dancers. They have no fear and there is no need of a safety net.

"Now follows the little Hawaiian dancer, the pet of the circus. She comes into view in grass skirt and lei. Her gliding movements and graceful hand study are an esthetic treat done to the strains of 'Dreamy Hawaiian Moon.'

"Olive Oyle brings Popeye into the ring in a jealous frenzy. His makeup is all inclusive, even to the can of spinach and heavy forearm. Olive Oyle surpasses the original in appearance and in acting and easily wins the prize.

"During the intermission the vendor passes popcorn and peanuts and after the performance various refreshments are available.

"Fortunes are told in the hospital cannery and it is midnight!"

LOOKING FORWARD

The Position of the Specialist

WHEN the Advisory Board of Medical Specialties was formed in 1933, some enthusiasts suggested that the time might come when no hospital would appoint as head of any of its special departments a man who had not been certified in his specialty. To some hospital administrators this suggestion seemed almost fantastic.

In the short period of five years, the situation has changed dramatically. There are in the current A.M.A. directory approximately 30,000 physicians who state that their practice is limited entirely to a specialty. The specialty boards have been failing from 30 to 40 per cent of applicants. If this ratio holds for the entire 30,000 then there are actually only about 20,000 qualified specialists in the United States. Of these nearly 12,000 have already been certified. The American Board of Surgery, which will ultimately certify the largest group of all, has just commenced its work. When it hits full stride in 1939 and 1940, the number of certified specialists will mount rapidly. In addition to the certifying boards, membership in the American College of Surgeons and the American College of Physicians carries certain indications of competence.

By 1942 or thereabouts, with few exceptions, all of the competent specialists in the United States will have received a professional certification of their competence. What, then, will be the position of the hospital trustees in making appointments to the medical staff? Obviously, any hospital that appoints as head of its surgical staff, for example, a surgeon who has not been certified when there are certified surgeons available in the community will be taking a serious risk. Would this hospital be meeting the requirement of the American College of Surgeons that "membership upon the medical staff be restricted to physicians and surgeons who are . . . competent in their respective fields"?

In employing nurses and other personnel the voluntary hospital is required by law to exercise due care to select only persons who are qualified to perform the tasks that will be assigned to them. Is there a possibility that the courts might eventually apply the same rule in the selection of the medical staff? After all, an appointment to the medical staff of a hospital is in

fact a recommendation to the public that a physician is competent to perform the duties commensurate with his position. The courts may hold that such a recommendation carries with it certain legal responsibilities.

The certification of specialists is an important public service and hospitals will be wise to study the situation carefully to see that its full benefits are made available to the public.

General Practitioner and Hospital

IF, AS implied in the preceding editorial, hospitals will soon appoint to the various specialty divisions of their staff only men who are certified in these specialties, what is to become of the general practitioners of the community? Are they to be denied all access to the four billion dollar hospital plant of this country?

Obviously, some provision must be made for general practitioners in the hospital family. They are the doctors who usually see the family first and for this reason are often called the nation's first line of health defense. Numerically they overshadow the specialists 5 or 6 to 1. It would be unfair to them and unwise from the social viewpoint to cut these men off from the intellectual and professional stimulus of hospital staff membership. Yet it would be dangerous and unfair to the public to hold them out as competent to do services that they should not perform.

Steps to dignify the place of the family practitioner should be considered. In an ideal system he should be the most important and the most respected member of the medical profession. He should be the arbiter among specialists, the coordinator of the points of view of the various specialists and the final judge as to the course of treatment to be adopted. In such a system, for example, no operation or other special procedure ever would be performed until the family practitioner is fully satisfied that the physical, social, psychic and economic results will be to the best interests of the patient. This would require him to have a better training than any specialist.

Without waiting for the realization of this ideal, however, would it not be practical to enlarge the staff by including a group of general practitioners or family medical advisers? Such men could be allowed to

practice in the hospital in the medical specialties to the extent that their training justifies. They would be required, of course, to call specialists into consultation whenever needed.

If the specialist is to be given a monopoly of the most important work in his specialty, then it is only fair to require him to stick to his specialty and to forego general practice. When a man of outstanding ability is qualified in more than one specialty, there appears to be no reason why he should not obtain more than one certification. After all, from time to time humanity does produce an Osler or a Welch.

The Private Patient's Dilemma

THE faith that the public has in the doctor often is difficult to understand. So complete, unquestioning and often childlike is this trust that the patient unhesitatingly places his life in the hands of a physician of whose judgment and skill he knows but little. To him the degree "doctor of medicine" is all inclusive. It implies an ability to practice medicine skillfully in all of its specialties.

None appreciates the fallacy of such a belief better than the leaders of the medical profession themselves. The hospital is mildly convinced of a duty to protect all types of patients coming to it for treatment. In this it succeeds to a greater degree in the case of the ward patient than in that of the patient in the private division.

One finds an entire lack of knowledge on the part of any but the physician in charge as to the happenings in the private room. No one but the physician in charge may insist upon consultation or other specialty services. No one else may require that aid be sought from other members of the staff. The restrictions of institutional etiquette so hem in the private patient that the most skilled specialty advice avails but little.

In the maternity department, however, there often exists an exception to this rule. Regulations may require a consultation after a patient remains undelivered for a definite period of hours and may restrict courtesy staff members to a definitely stated type of operative procedure. Here also a young courtesy staff obstetrician may obtain a free staff consultation if his patient is unable to pay. But in the case of medical and surgical private and semiprivate patients such provisions rarely are made.

It may be said in extenuation that there are some good reasons why the practice of the physician in the private division should be subject to no interference. Yet a hospital that does not define the type of surgical privilege, for example, that is granted to courtesy and to younger staff members is distinctly unfair to its clientele. There can be no sparing of the physician's feelings when a human life is at stake.

In the files of the administrator, the admission office and the operating room there should be a card for every courtesy and junior staff member, describing the type of work that each is permitted to do. The hospital betrays its trust to its community if it permits unsafe or unnecessary surgery to be practiced because it needs increased income.

Training the Surgical Intern

INTERNS often look forward to their surgical service, hoping to be permitted to perform major operations. Some surgeons even are convinced that it is proper to allow an inexperienced intern to operate with but scanty supervision.

To follow such a policy cheapens the specialty of surgery. There are those who believe that the surgeon's technical skill in cutting and sewing is subordinate, that the skill and judgment required in deciding when to operate are more difficult to acquire than the necessary manual dexterity.

Young physicians who have performed a half dozen laparotomies or herniotomies and have noted that patients' wounds quickly heal and uncomplicated convalescence follows rashly conclude that they are surgeons. Leaving the hospital, they undertake major surgery in ill supervised smaller institutions in which the only requirement is for the physician to provide a willing pay patient. In such hospitals questionable treatment is carried out by poorly trained surgeons and no one calls a halt.

It is more valuable for an intern to spend many hours in the surgical dispensary perfecting his technic in the handling of the type of condition that he is likely to meet in his office than for him to be permitted to do solo operating when he becomes a surgical intern. No doubt from some source will come a sufficient impetus to rearrange surgical services so that residents in surgery will receive a greater number of hours in the operating room and interns, laying the foundation for general practice, will be specifically prepared for the kind of work that they will find necessary. A surgeon is not made merely by spending from three to six months in the surgical department of a hospital during a rotating intern service.

Operating Room Crudities

THE administration of a spinal anesthetic formerly was a rarity that attracted much attention in the hospital operating room. Now, this type of anesthesia is growing so common that in some hospitals an insufficient number of inhalation anesthetics are produced to meet the state board requirements for the intern staff.

With the increased use of local and spinal anesthetics a new problem develops in operating room

management. For example, we may see a still conscious patient exposed to the sights, sounds and odors of a busy operating clinic. Nurses and doctors generally have yet to learn that protecting a conscious patient from unnecessary shocks to his nervous system is a vastly different matter than protecting an unconscious patient. Loud talking, banging of basins and the clatter caused by dropping surgical instruments have no place in an operating room in which a patient under a spinal anesthetic is being treated.

It is dangerous to frighten a patient by allowing him to listen to the conversation of surgeons gathered about the scrub-up sink as they discuss a cancer, a postmortem or other clinical matters.

Perhaps the solution lies in a reduction of operating room personnel. Possibly a different preoperative procedure or treatment is needed in which a sort of twilight sleep is produced so that the patient is oblivious of his surroundings before and during an operation.

Certainly, the operating room, whether it is being employed for the treatment of a conscious or of an unconscious patient, should exhibit an atmosphere of quiet and orderliness. Noise caused by clumsy handling of instruments or by moving apparatus or equipment should not be permitted. A good operating team requires the highest degree of finesse and skill in the presence of a conscious patient.

Handbag Diagnoses

FROM supposedly authoritative sources comes the statement that 85 per cent of all illnesses may be satisfactorily diagnosed and treated at home. Thus it is assumed that the general practitioner possesses sufficient skill and carries in his bag the necessary apparatus to diagnose promptly the majority of diseases that he encounters.

Most minor and a fair percentage of major illnesses have a natural tendency toward improvement. Hence, it is difficult to evaluate the diagnostic and therapeutic efforts of the general practitioner, since many patients are likely to recover with but little aid. It should also be conceded that the general practitioner often acquires an effective, almost uncanny, intuition and skill in making diagnoses without costly laboratory apparatus.

It is questionable, however, whether the average medical case can be diagnosed at home by a busy general practitioner as promptly and accurately as by a more deliberate laboratory and clinical survey in the hospital. There are many surgical conditions that require the services of the clinical laboratory and the x-ray department for diagnosis. Since these aids are not available outside the hospital it is difficult to determine with certainty the relative efficiency and speed of diagnosis and therapeutics in the home as compared with institutional practice.

Probably a considerable percentage of patients treated at home would be much more quickly restored to health if a hospital bed and excellent diagnostic facilities were available for them.

Some practitioners hesitate to hospitalize their patients because they are neither permitted to treat them in a ward bed nor, if this arrangement is possible, can they charge for such services. No doubt, as hospital care insurance plans develop, family practitioners will find to their surprise not only that they may employ the services of the hospital more fully but also that institutional facilities greatly simplify the handling of their patients. When by this means a greater utilization of hospital beds results, such doubtful diagnoses as "intestinal grippe," "nervousness" and "acid system" no doubt will be replaced by a more truly descriptive clinical nomenclature.

Questionable Practice

IT HAS become common for hospitals, on donation day, at holiday time and during fund raising campaigns, to request advertising in memorial booklets, added discounts on the cost of goods purchased or an out-and-out contribution from firms with which they deal. This is questionable practice. While some hospital administrators have endeavored to make clear that the absence or presence of a contribution will in no way affect present or future business relationships, still there often exists a veiled intimation relating to the hospital's displeasure or disappointment if such requests are not granted.

No institution has a right to add to the expense of hospital equipment and supplies which others must purchase by the adoption of a policy that smacks both of unfairness and of selfishness. If contributions must be requested and advertising space in bulletins or memorial books must be sold, it would be far less compromising to seek assistance outside the field from which the hospital purchases its goods. On this point it is refreshing to find a frank request from the purchasing department of a public service company in an Eastern city asking that no remembrances be sent to its employees at Christmas time.

The administrator of the hospital often is placed in an embarrassing position by the receipt of presents from those from whom he purchases. If they are of value, and the administrator is conscientious, he returns them with thanks. However, he is put to a great deal of trouble and effort to return cumbersome presents of edibles or other similar articles.

Hospital supply houses should be protected against the embarrassment of refusing or acceding to requests made by institutions with which they trade. The remedy for this ill lies in the hospital itself. The institutional code of ethics should contain a strong condemnation of this practice.

Setup for Hospital Dental

DAVID TANCHESTER, D. D. S.

SOME hospitals, realizing the necessity of conforming with the progress of medicine, have had the foresight to include a modern dental clinic in their plans. To render the best service possible, most observers will agree that a well-equipped and adequately manned dental clinic is a necessary part of the hospital organization. Without it the hospital is bound to fall short in the attainment of its several objectives.

Dental service must be considered on a par with all other clinical services. It is fair to say at this stage in the development of hospitalization that the quality of dental service in hospitals is an index of their progressiveness.

On admission to a hospital a thorough dental examination, with x-rays of the teeth and their surrounding structures, should be included with the general physical examination. The only exception occurs in emergency admissions. The profession of dentistry is no longer limited to reparative work requiring mere mechanical dexterity. Both the medical profession and the laity are acquainted with the progress that has been made in this field and know that it is on the same plane as the other healing arts.

"There is no lesion or wound that is local," said one writer recently. The oral cavity with its teeth and supporting structures is a part of the body which may cause disease elsewhere and which may become diseased as a result of systemic ailments in other parts of the body. Obviously, therefore, dentistry plays an important rôle in the well-being of an individual. Since dentistry assumes responsibilities similar to those of the other specialties of medicine as a biologic health service, the dental department of a hospital should be a place of contact where the physician and dentist may cooperate for the patients' best interests.

There is a close relationship between the dental service and other hospital services. The radium clinic

frequently depends on the dentist to construct appliances to hold radium packs in place. Patients should have all pathologic conditions in the mouth treated, or, at least, prophylaxis done before a general anesthetic is administered in the operating room. Patients who are recuperating require proper restoration of teeth as an aid to recovery. Restorative dentistry also plays an important part in the treatment of gastric conditions and of tuberculosis, since patients thus afflicted must be able adequately to chew food for good digestion.

The dentist is in a position to recognize many ailments while making a thorough examination of the oral cavity. There are lesions in the mouth that he can recognize as being suggestive of systemic involvements. Blood dyscrasias, tuberculous lesions, syphilitic lesions in first and second stages, diabetes, benign tumors, pemphigus, pregnancy changes, metallic poisonings and endocrine disturbances can be noted by the dentist. These conditions can be brought to the attention of the respective medical services and thus a systemic disease may be checked in the early stages.

Central Location Mandatory

In view of the fact that all patients must be seen by the dentist, it is essential that the dental department be centrally located in order to avoid too much traveling from the bed to the clinic. It should be situated where it will be accessible to wheel chair patients. The best location is one near the general surgery rooms of the hospital.

The plan here proposed is an ideal one. However, the importance of dental service as a cooperative agent with other hospital services is so vital that in a hospital in which finances or space will not permit all the facilities indicated in the following description, some type of dental service is essential.

The ideal dental clinic should have all of its activities in one unit, the various subdivisions of dentistry being in separate rooms. The following plan is recommended: the corridor should lead into a large central waiting room, with the desk of the secretary at the right side of the room. Here the patient presents his sealed medical case history to the secretary, who informs the dentist assigned to the case that his patient has arrived.

Location of Services

To the right, in counterclockwise formation, there should be in succession:

1. The prosthetic clinic, which should contain an adequate number of chairs, Ritter units and a workbench for necessary mechanical operations which the dentist wishes to perform while the patient is in the chair.

2. The operative clinic, which should have a chair, an operating unit, a workbench and a glass cabinet for models.

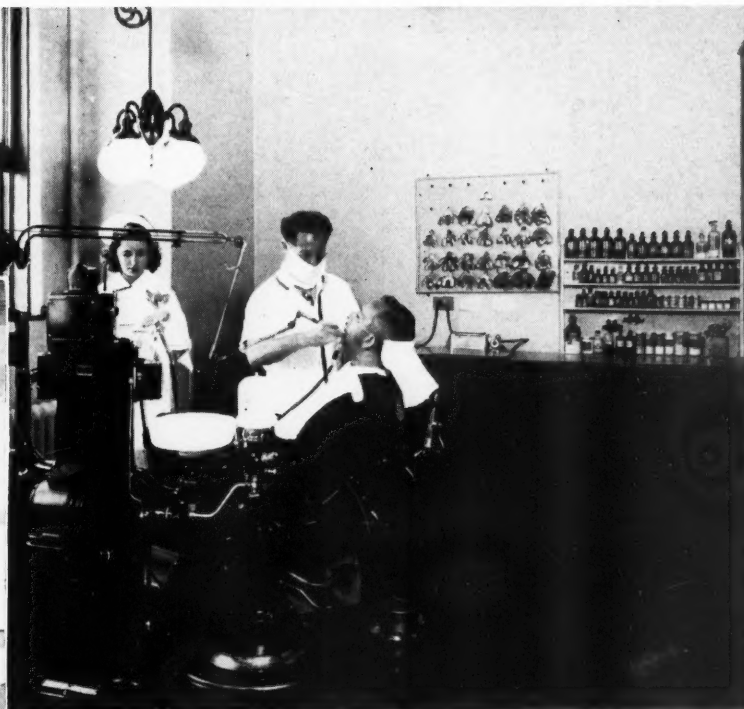
3. The sterilizing room, which should have one small sterilizer for syringes and needles, a large sterilizer for instruments, an autoclave, drums in which to store sterile linens and several cabinets for storing instruments and supplies. This room should have an opening on each side so that sterile trays can be handed to the men with ease. It should be situated close to the operating chairs.

4. To the left of the sterilizing room should be the surgery clinic. This should contain a chair, a surgery spotlight, operating tables for trays of instruments and an x-ray illuminating box. The chair should be so situated as to leave sufficient space so that the men may observe the various operations. Folding doors which, when opened, provide ample space for clinical demonstrations and lectures are preferable.

Clinic



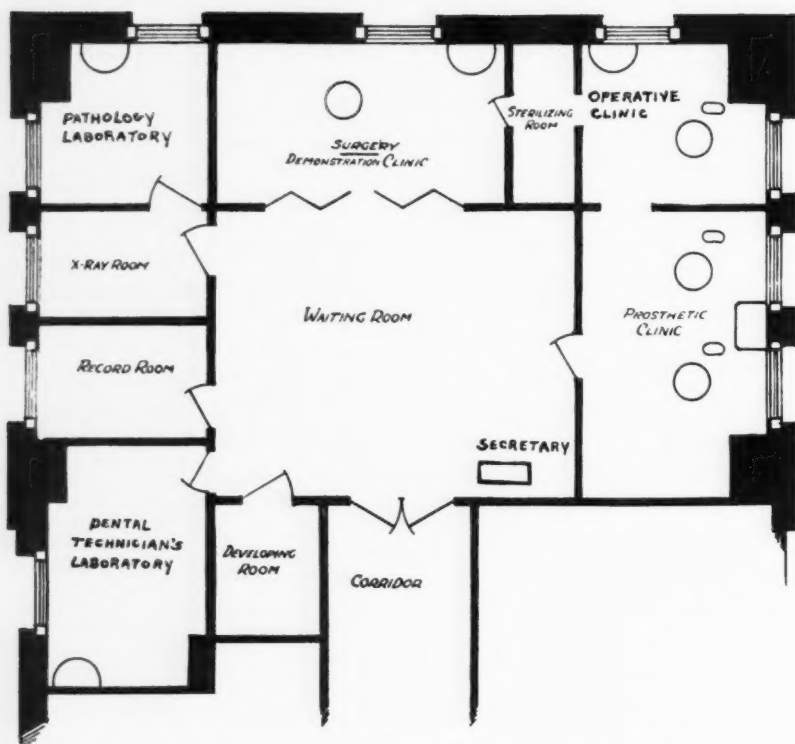
Above: A corner of the surgery demonstration clinic. Below: The dental technician's laboratory is equipped with machinery for making all types of restorations.



In the prosthetic clinic, chairs and Ritter units are conveniently located near the workbench. Above it is space for completing the necessary mechanical operations and below is a plentiful supply of drawers for storing extra materials and additional instruments.



The dental assistant issues tray setups from the sterilizing and instrument room. She also is responsible for sterilization of instruments and supplies and for taking the department inventory.



Every type of dental work can be handled in this well-planned department.

5. The pathology laboratory should be located to the left of the surgery clinic. This room should contain a worktable, a chair, a microscope and shelves for all the chemicals needed for the preparation of slides.

6. To the left of the pathology laboratory should be located the x-ray room, with the x-ray machine, chair, safety receptacles for the storage of unused and used films and a small table.

7. Placed in juxtaposition to the x-ray room should be the record room, in which there should be cabinets large enough to include duplicate dental histories and space for the filing of charts, x-rays, photographs and laboratory reports. A few chairs, a desk, a typewriter with a typewriter table, a bulletin board and shelves for catalogs, books and magazines should be provided.

8. The dental technician's laboratory comes next. This should be equipped so that all restorations can be made on the premises. Vulcanizers, casting machines, a polishing unit with an exhaust fan, cabinets for storing materials and small implements, an electric engine and shelves for models and cases that are in the process of being completed should be provided.

9. The developing room, which is

the last in line, should contain a developing unit, shelves for storing clinical cameras, photographs, x-ray materials and racks for processing and drying films.

These nine rooms have the shape of the letter U with the waiting room in the inside and the corridor at the open end.

All of these rooms should be completely equipped with lighting and plumbing fixtures and should contain air, gas and electric outlets. Reference to the floor plan diagram will present the relationships of these rooms more clearly.

Patients on wheel chairs or stretchers may receive treatment in such a dental clinic because the doors are wide enough to permit the passage of equipment of this kind. Dental chairs can be moved to facilitate treatment. A portable engine and a kit of instruments should be available for use at the bedside of those patients who cannot attend the dental clinic.

The dental department at Montefiore Hospital, New York, has 24 staff members and is governed on a democratic basis. Although the chief of the service, who holds the title of attending dentist, is in charge, he is the senior member of a small advisory group composed of such rep-

resentatives as the oral surgeon, the periodontist, the dentist in charge of the Country Sanatorium, the dental pathologist and coopted members for special purposes.

The following check list presents an ideal plan for the administration in a dental department:

Attending dentist	Adjunct dentist
Associate dentists	Assistant dentists
Oral surgeon	Interns
Pathologist	Dental technician
Prosthodontist	Hygienist
Periodontist	Secretary
Orthodontist	Dental assistant
Radiographer	Orderly
Root therapist	Porter
Operative department	

Duties of the Attending Dentist.—

The chief of the dental department should be a general practitioner who has the fundamental knowledge of all the specialties in dentistry and who is conversant with the practice of medicine. The chief should be responsible to the administration of the hospital and should present regular reports of the work of the department to the director of the hospital. In order to keep himself well informed about the other services of the hospital and to keep others informed of his work, he should be a member of the medical board. By attending medical board meetings, the dental chief will be instilled with the high standards of the other services and will be able to inform the other chiefs of services of the co-operation of the dental department and the work accomplished by this division of the hospital.

The attending dentist should be on call at all times. He should visit the department at least twice a week. It should be his duty to see that patients are receiving the treatment that they require. It is he who should instill into the men the desire to progress in research and in all fields of industry. It is important that he arrange weekly general meetings at which all the work of the department can be coordinated. At regular monthly meetings, attended by the medical and dental staffs, the chief should act as chairman of the meeting and present to the staffs the various problems of the month. All material that members of the dental staff desire to publish or present to

outside groups should receive his approval. It should be his responsibility to consider all requisitions.

Duties of the Associate Dentists.—

The associate dentists act as liaison officers between the rest of the dental staff and the attending dentist. The associates are men who are specialists in their respective fields of dentistry and who possess educational and investigative capacities. They should be present in the clinic at least once a week. They should be responsible for all the work done in their respective departments. Difficult cases should be brought to their attention for consultation. They should diagnose these and prescribe treatment. They, themselves, operate when a difficult case is presented or when it is essential that they demonstrate technic for educational purposes.

Duties of the Adjunct Dentist.—

The adjunct dentist should be one who has been a general practitioner for several years and who is progressive. It should be his duty to assign the work for the day. In the absence of the attending dentist or the associate, the adjunct is in charge for the day. He should be capable of diagnosing all cases and should request consultation with an associate whenever necessary. He should be responsible for the proper examination of patients and for the completion of the work in accordance with definitely established technic.

Duties of the Assistant Dentist.—

The assistant dentist should be one who has a few years of practice or who has successfully served at least one year of internship. He is responsible to the adjunct in charge for the day. He must follow prescribed technic in all types of work and must undertake no work unless an assignment has been made and duly signed by an adjunct. No change in the assigned work should be permitted unless, after having consulted an associate, the latter has deemed that necessary. The assistant dentist should request consultation only through the adjunct.

Duties of the Dental Intern.—The dental intern should be graduated from a grade A school. His personality and character should be satisfactory. His hours in the clinic should preferably be from 9 to 12

a.m. and from 1 to 5 p.m. He should be on call at all times. He must abide by the rules of the house staff generally. He should perform the work according to the prescribed technic recorded on the dental chart and may not perform any operative procedure that has not been specifically ordered.

It should be the dental intern's duty to take complete x-rays on all new patients. He should not be absent from the clinic without the permission or knowledge of those in charge. He should be observant and report any unusual case to those interested in that branch of study. Those patients who have undergone operations during the day should be viewed by the dental intern on the evening of the same day. After clinic hours, he should see both newly admitted patients and those who have been unable to attend the clinic. If, after a year of internship, he has shown sufficient initiative and co-operation, he should be retained on the staff as an assistant dentist if there is room for him.

Duties of the Dental Technician.

—The technician must be well trained in all phases of mechanical dentistry. He should have a full-time position in the clinic and be at the call of the dental staff at all times to take instructions in regard to the construction of restorations and the esthetics involved. He should be prepared to render emergency service. To have the technician in the clinic is conducive to a saving of time for the patient and dentist, an element that is of vital importance. Patients who are greatly in need of teeth for proper mastication to help them recuperate benefit by prompt service. The technician at the hospital has the advantage of being able to observe, under the guidance of the dentist, the progress of the work done in the mouth of the patient. Better dentistry can be done under such an arrangement.

Duties of the Oral Hygienist.—

The oral hygienist should have received special training in a grade A school in the cleansing and polishing of teeth and the preservation of surrounding tissues. She should be capable of teaching patients oral hygiene and the proper method of brushing teeth. She should assist the dentist

at the chair. She must be able to take, develop and mount all of the department's x-ray films. It should be her duty to make rounds on the wards with the dental staff. The portable engine and prophylactic set of instruments should be available for her use at the bedside of those patients who cannot attend the dental clinic. The hygienist should be entrusted with the preparation of trays for any surgical procedure.

Duties of the Secretary.—It is the secretary's duty to keep all records, which shall include the daily record sheet of patients treated, together with the names of the dentists who operated and the weekly and monthly compilation of work done. She should keep a list of newly admitted patients and of those about to be discharged. She should call patients to the clinic and arrange to have them returned to the wards. It is essential that she keep an account of all supplies on hand and that she present all requisitions to the attending dentist for his consideration and signature. She should be capable of performing all the duties of a competent secretary and should also have a knowledge of medico-dental terminology.

Duties of the Dental Assistant.—

The dental assistant should act as a helper to the hygienist and should be capable of assuming all the duties of the latter, except the practice of scaling and cleaning teeth. She should wash and clean all instruments which have been used before placing them in the sterilizers. All instruments and motors that require oiling come under her care.

Duties of the Orderly.—It is important that there be a man in the department to act as an orderly. It should be his duty to bring patients to the clinic and return them to their rooms. In this way he relieves the orderlies on the wards, who do not have to be called away from their routine tasks. He should deliver drugs from the pharmacy and materials from the storerooms.

Duties of the Porter.—There should be a porter in the dental department who should clean the department daily and polish all equipment. However, the oiling and care of intricate machinery should not be entrusted to him.

The Small Hospital

Food Clinics—

THE Salem Hospital, Salem, Mass., is a community hospital of 150 adult beds, serving a population of 60,000 people with active services in every department, including obstetrics and pediatrics. The out-patient department has been in operation since 1874 and it now serves an average of 37 patients per day in the various clinics that are customary in a community hospital.

The importance of diet in the care of house patients has always been appreciated and our medical staff has likewise valued the work of the dietary department in interpreting the diet orders in terms that can be understood by the patients. Because of the keen interest of the medical staff and dietitians, the same consideration of patients' diets is given to those being treated in the out-patient department. Out-patients need help on food problems perhaps even more than house patients, partly because there is less opportunity for actual diet control.

Reasons for Food Clinic

To be specific, the Salem Hospital out-patient department has a diet or food clinic for the following reasons:

1. To teach the patients the value of a normal diet for normal health.
2. To interpret the doctor's diet prescription for the patient's particular disorder in simple food language that the patient can understand.
3. To adjust the diet to the financial status of the patient.
4. By proper diet to help develop better health in the community.

The first problem, and perhaps the fundamental one, is to develop a consciousness on the part of the clinic doctors, and particularly the interns, of the value of the dietitian and her food clinic to them and to the clinic patient. The interest and enthusiasm of the administrator are of the utmost value to the dietitian in this problem. Talks to the medical staff, educational exhibits and repeated demonstrations of the value of a food clinic help materially in developing this attitude.

The food clinic operates on specific days, particularly on the days of the prenatal and pediatric clinics and in collaboration with the other clinics. The dietitian is on call for other days of the week. Doctors in the clinics avail themselves of the opportunity of having the dietitian interpret their orders to the patient. This clinic thus saves time for the doctors and really gets the story across.

Even in the small hospital with one dietitian and with a small out-patient department, where it is not practical to have a set time for the food clinic, the dietitian can be on call for special cases. This does not do a complete job, but it helps materially in the problem, particularly if the dietitian has developed a consciousness of the value of the food clinic in the minds of the clinic personnel.

When a patient is referred to the food clinic she is met by the dietitian who endeavors to develop a friendly relationship to win the patient's confidence. The dietitian then asks questions to find out exactly what the patient does eat. She adjusts her ideas to the particular income or racial diet standards of the patient and then outlines the proper diet for the patient in accordance with the doctor's order, giving the patient a detailed menu sheet.

As the dietitian outlines each meal carefully and individually she sets up

in front of the patient models of the several food items. The use of models enables the patient to visualize the diet and thus it is impressed on his mind more adequately than by the spoken word or by the printed list.

This food clinic benefits the hospital in many ways. Naturally the experience is beneficial in the training of interns, dietitians and nurses. Thus, the hospital benefits from the standpoint of improving the educational program and from the favorable reactions it receives for its public health work.

The value of such a clinic to the community at large is derived from the benefits to the patients themselves. Improvement in diet standards causes a general improvement in health and this food clinic is, therefore, a valuable adjunct to the public health work being done by the hospital.

Measuring the Value

The effectiveness of the food clinic in reaching the individual patient, multiplied by the number of patients, determines in great measure the value of the food clinic to the community.

The clinic's value to the patient depends on the ability of the dietitian to interpret the doctor's orders in language the patient can and will understand and to select items that are within the reach of the patient's pocketbook.

The development of a consciousness on the part of the clinic staff, including the interns, the approach to the patient and the detailed operation of the food clinic are the prime considerations in this problem.

Certainly, if we in community hospitals are to assume our responsibilities as public health agencies, the food clinic in the out-patient department is a necessity and can be operated to great advantage even in the smallest hospital.

Introducing a series of articles on food clinics to appear in the Food Service section this year are these two articles written from the administrative point of view

A Health Service The Large Hospital

F. R. BRADLEY, M.D., and LOUISE WILKONSON

OUR interest in food clinics began with the opening of Barnes Hospital in December 1914. At the time the need for a food clinic was recognized. The hospital opened with the metabolism unit with a capacity of six patients. This unit has its own kitchen, dietitian, special nurses and a large and well-equipped research laboratory conducted by the Washington University School of Medicine, St. Louis. Because of the affiliation of Barnes Hospital, St. Louis Children's Hospital, Washington University Clinics and the Washington University School of Medicine, the work of the food clinic has been divided among the various hospitals in the group and the Washington University Clinics.

Since 1914 the hospitals have furnished food clinic service to private and semiprivate patients and to selected ward patients who return to their respective hospitals for food clinic service instead of to the clinics. From the first Washington University Clinics has had a dietitian who gave food clinic service to a few patients. In 1925 the medical director of Barnes Hospital metabolism ward also was assigned to the Washington University Clinics, enabling the clinics to care for more patients and the hospital to follow its ward patients who return to the clinics. However, patients suffering from diseases that are under study, such as diabetes, nephritis and Addison's disease, return to Barnes Hospital metabolism unit instead of to the clinics because laboratory service is more readily available.

The Washington University Clinics, feeling acutely the need for a formal food clinic, organized one in November 1931.

In Barnes Hospital, which cares for adult medical and surgical patients, the food service is highly integrated. The Tirrill metabolism ward has grown from the original

six rooms to a complete ward of 14 beds, including two private rooms. It has a model diet kitchen, containing a breakfast nook so that the patients may be instructed as to their diet, including how to prepare it and how to calculate it. There is a basal metabolism room adjoining the ward and near by there is a completely equipped research chemical laboratory for study and research in metabolic and similar diseases. A full-time dietitian attached to the ward gives instruction to student nurses from the Washington University School of Nursing. Instruction also is given to junior medical students from Washington University.

The preparation of calculated diets for in-patients carried on in this metabolism unit is not, in a sense, strictly food clinic work. However, it becomes such when the patient is to return home and it is necessary to educate him in the preparation and calculation of his diet. This is especially true if the patient is a diabetic or is suffering from vitamin deficiencies, particularly if he is going into a rural community with no clinic or hospital near. If he is a foreigner who speaks English poorly, it is necessary to educate him and to obtain the cooperation of his relatives so that they may translate or carry out our instructions.

Adapting the Diet

The metabolism dietitian makes rounds with the medical director of the unit and this enables her to know at once the diagnosis and the full medical requirements of the case so that she can build a patient's diet around the medical requirements and at the same time adapt the diet to the patient's social and financial status.

The integration of the Barnes Hospital metabolism unit with the food clinic in the Washington University Clinics is of distinct advantage to the

hospital in that a close check is kept on hospital patients who have become out-patients; often the expense of another hospitalization is avoided. From the scientific standpoint, the director of our metabolism division has been enabled to work out research problems in metabolic diseases, chiefly diabetes and nephritis, over a longer period of time than would be possible otherwise. Of distinct advantage to the patient is the fact that if he is appearing regularly at the out-patient department for observation in the food clinics and should need hospitalization, let us say for diabetic or uremic coma, or the crisis of Addison's disease, he may be admitted in the early stages.

Research in Metabolic Diseases

St. Louis Children's Hospital furnishes food clinic service to its private and semiprivate patients and its ward in-patients. It also has integrated the food clinic service with its own research department in metabolic diseases and the Washington University Clinics.

In addition, the department of pediatrics oversees the dietary requirements of infants in St. Louis Maternity Hospital. The arrangement whereby patients suffering from diseases under study by the research department of Washington University School of Medicine may be returned to St. Louis Children's Hospital for study instead of to the clinics enables the department to adjust the food clinic's work to research problems as they are indicated. Patients are more readily available for the instruction of the intern staff and medical students in the clinical handling of these special patients and of out-patients' problems.

St. Louis Maternity Hospital has a full-time dietitian who instructs the mothers in regard to their diet as they are discharged, the diets for the babies being handled, as has been stated, by the department of pediatrics in St. Louis Children's Hospital. Out-patients return to the Washington University Clinics for food clinic service.

Beauty Enters the

RAYMOND P. SLOAN

"I FEEL like a million dollars!" Did you ever hear anyone make this statement who didn't look in top form—her top form, at least, or his? It is uttered, no doubt, as she emerges from a beauty parlor glowing with life and interest after a shampoo, a wave or a facial. Or said with a resounding slap on your back, as he proceeds to rub a velvety smooth chin dusted ever so faintly with violet talcum. "Ready to lick the world—I'll say."

If to be well groomed adds to the self-respect and comfort of those who enjoy normal good health, what benefits might it have for others who lie convalescent in a hospital bed? Think of the psychological effect upon the listless patient of a dry shampoo and scalp massage, a wave or a facial. Unfortunately it is not always recognized that towseled, matted hair can cause as intense discomfort as an aching back.

Imagine, too, the pleasure the patient derives in seeing about him, as he appraises life with new eyes, a group of unusually attractive nurses

—immaculate young women whose caps are placed at just the right angle atop their sleek, becomingly dressed hair, whose skin looks fresh and clear, whose hands belie the rigors of hospital routine, and, wonder of wonders, who do not walk as though every step is an effort.

Two years ago, a hospital in New York City began to visualize the value of beauty service for its patients

as well as for its entire staff. Assuming that there is truth in the statement, "We feel as well as we look," this institution decided to experiment and find out if modern scientific treatment of the hair, skin and nails would not actually hasten the patient's convalescence and also develop a better morale among the personnel. The decision was reached after a careful examination and study of the

Right: The main treatment room that opens off the lobby. Below: The visit to the beauty shop is an occasion eagerly anticipated by patients, who are taken to the shop in a wheel chair by an attendant.



attitudes of patients, doctors, nurses and beauticians.

Doctors admitted that the idea had possibilities; patients and nurses alike were enthusiastic; a beautician of national reputation was discovered who envisioned in the project opportunities for raising the standards of his profession. So it happened two years ago that Manhattan General Hospital announced a new service, thoroughly modern beauty facilities for patients and employees. Time has brought even stronger conviction that a well-organized and carefully supervised beauty salon can and should play a part in the conva-

Hospital

lescent care of patients in our hospitals today.

Treatments of the skin, scalp and nails are administered in a suite of eight commodious rooms at Manhattan General Hospital to those patients who have received the approval of their doctors, also to nurses and other members of the staff. Some of the work is carried on at the bedsides, always with the doctors' per-



Treatments frequently are given to patients confined to their beds. The doctor first must give his approval and an appointment is made for a dry shampoo, a facial or a manicure.

mission, by operators carefully selected and especially trained. The girls must have a sympathetic nature, present a good appearance and, most important of all, talk only when spoken to.

Walk down the main corridor on the first floor and turn to the left. The visitor enters a small foyer containing an appointment desk and a glass show case in which are displayed numerous silver trophies awarded to Adolph, the beautician who eight times has received the national prize for hair dressing and who for three years in succession has won the international prize. Adolph

operates the department under the general supervision of Helen Murphy, R. N., superintendent. In addition to the hospital work, he has his own customers from outside who, once having recovered from the shock of visiting a hospital for a wave or a manicure, are enthusiastic over the advantages.

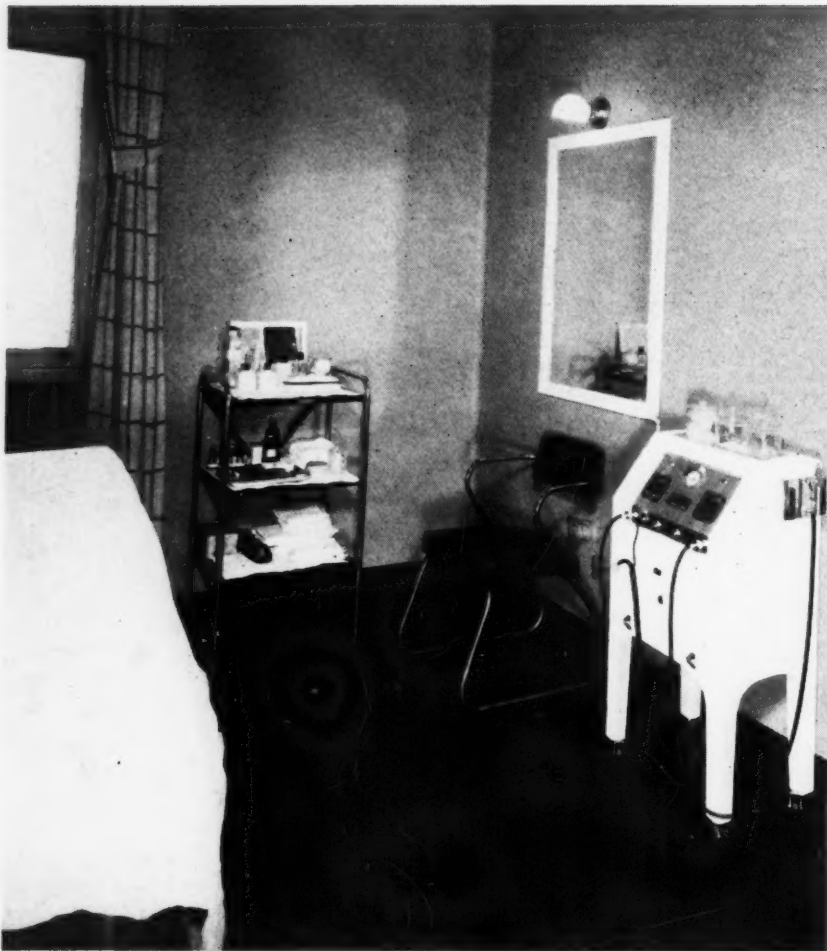
It is not unlikely that the sound of men's laughter will reach the visitor as he starts to learn at first hand of beauty therapy in the hospital. It comes through a half-closed door at the left that leads to the men's salon, or barber shop. A doctor, his face immersed in lather, is discussing bald

heads with the barber and with a patient stretched out in a wheel chair. The talk is of the wonders performed by a woman employed in the salon in making hair grow on the most barren spots. The doctor, one of her patients, proceeds to present proof of his claims.

Through another doorway can be seen the reception room and main treatment room with its four chairs and four manicure tables, with plenty of space left for lounges and settees. Farther down the hall are six treatment rooms, each with accommodations for two. When possible, patients are assigned separate rooms, thus assuring them complete privacy. High ceilings, adequate space and quiet create an atmosphere far removed from the hustle and bustle of the average beauty salon. The patients speak of it. They like it and even come back after being discharged from the hospital, because it's so restful.

It is distinctive, too, in its decorative effect. Color dominates, aquamarine tints being combined with bold orange to disguise successfully the old-fashioned high ceilings.

The equipment harmonizes and is characteristically modern. Recently a



Portable equipment that makes it possible for convalescent patients to have their hair and skin cared for without leaving their rooms.

new machine for permanent waving was purchased at a cost of \$400, making two in all. Not that there is much call for permanent waves by the patients. "Most women have a permanent before they go to the hospital," Adolph explains. "It would be too taxing on the majority of convalescents."

But nurses and customers from the outside keep the machines busy. It is not unusual to find Adolph and his staff still winding up the curlers as late as 10:30 or 11:00 p.m. Nurses have to be taken care of when they have the time. Six people assist Adolph: a barber, a combination barber and hairdresser, two girls who give manicures among other duties, a cashier and the woman who specializes in scalp treatments. In addition, there are generally two apprentices.

A capital outlay of between \$6000 and \$7000 is represented, for the equipment also includes portable machines that may be rolled alongside

the bed for facials, as well as dryers and lights. Then there are the treatment chairs and other furniture. With such facilities available, it is not surprising that the patients enjoy the variety of being wheeled down to Adolph's to get "fixed up." It becomes a real occasion to which they look forward, a welcome interruption to hospital routine.

Just as relaxing and beneficial are the treatments given those patients who are confined to their beds. While their bodies are rebuilding, their hair and skin likewise are being properly nourished. Following the call of the young lady attendant, the sanction of the doctor is obtained and an appointment is made. Soon the necessary equipment is rolled up to the bed and the treatment starts—a dry shampoo, perhaps, or a facial or a manicure. As she finishes, the operator takes the machine and gives the patient in a light arm and hand massage, which is soothing and relaxing. In consequence, the hair soon

regains its lustre, the skin takes on the glow of health and the nails become smooth and strong. Many a doctor confesses that he has to be introduced to his patient all over again. And the patient admits that she feels like a different person.

Occasionally, during these treatments, either upstairs or in the beauty salon, a condition of skin or scalp reveals itself that is baffling to the attendant. No chances are taken. A doctor is called in conference. This tie-up between the beautician and the medical staff is particularly significant.

So daily we find the young woman representative of the beauty salon making her rounds, greeting new patients and stopping for a minute or two to chat with the old. If a wave does not look right to her practiced eye, she steps over to the bed or the chair and adjusts it. If, by chance, nail polish has become smudged, she proceeds to repair the damages. Under her skilled hands the patient is kept looking as fit as possible, at no extra charge. Even the initial cost is moderate; a hair set, for example, that ordinarily would be 50 cents in the salon is 75 cents in the room.

Special concessions are made to the nurses. To encourage interest in personal appearance, they are offered complete beauty care for \$10 a month. This means that once each week every girl who subscribes receives a shampoo, a wave, a facial, a manicure and, what is even more important for nurses, a pedicure. If they choose to do so, they can also stop in at the shop whenever they have a few minutes and have their hair set, at no extra cost. Some adopt the upswept mode at the end of the professional day. Small wonder that Manhattan General's nurses are well-groomed!

Nurses from two other hospitals in the neighborhood likewise avail themselves of the service, for the community does not boast many beauty parlors and none as pretentious as the one at Manhattan General. Outside customers pay the regular rates, however.

It is not as superficial as it sounds. Maintaining herself in this way gives the nurse a different outlook on life and if anyone needs to feel "like a million," it is she.



One of the eight treatment rooms maintained by the shop. Two permanent waving machines are kept busy caring for nurses and outside customers. Nurses from two other hospitals make use of the shop.

Mention of the new upswept hairdress recalls an incident that will not soon be forgotten at Manhattan General. As accustomed as hospital people are to unusual sights both amusing and distressing, they confess frankly that this was a new one.

A woman patient about to be discharged was particularly anxious to look her best when she left the hospital. A group of friends, it seems, were giving her a "welcome-back-from-the-hospital" party. If only she could surprise them by appearing with one of the fashionable upswept coiffures! The chief difficulty was that her hair might become disarranged on the way home. Adolph arose to the occasion by suggesting that he dress her hair around her hat.

So behold our patient on a warm afternoon in late summer being rolled along the corridors of the hospital garbed in pajamas, but with her hair high on her head topped with a saucy speck of a hat.

An amusing incident, to be sure, yet something more—a situation reflecting a state of mind that is too infrequent among the thousands of patients who depart daily from our hospitals. This wasn't an invalid returning to her normal environment, fagged, spiritless, indifferent, but a woman exuberant, confident, glam-

orous, feeling fit because she looked fit. No expressions of sympathy awaited her but instead there were cries of admiration: "My dear, whatever did they do to you? Why, you look marvelous, simply marvelous. Come, turn around and let us see it from the rear."

How envious would another patient have been could she have heard

the foregoing comments! This other patient was discharged from a hospital that boasts no beauty shop. Upon hearing about what is happening at Manhattan General, she wrote Miss Murphy a note.

"I want to tell you what a splendid idea I believe this to be. Only too well do I recall leaving a hospital after three weeks of illness. Unfortunately, I am one of those people whose hair, to look at all decent, must be done every 10 days. No beauty help was available at my hospital, only a barber who claimed to be a hair dresser but who, in my opinion, was only a barber.

"I reached home looking like 'something the cat dragged in' and the thought has often come to me since how splendid it would be for hospitals to be able to fill the beauty needs of their convalescent women patients.

"Nothing helps one's morale more than a good facial or a hair-do. Doctors will find patients far more cheerful if the patients know they are looking their best. You must agree with me, since you saw the need and acted upon it. Here's a salute to beauty."

This by one who speaks from actual experience. More such frank expressions may well encourage more hospitals to throw open their doors to admit beauty. Who can tell?

Passavant Has Unusual Crèche

FROM Italy come the graceful figures used in the crèche displayed in the lobby of Passavant Hospital, Chicago, during the Christmas holidays. Built by Mrs. James Ward Thorne, well-known collector and constructor of miniature interiors, the crèche follows the traditions of the early Italian, even to the mound of fruit and gifts placed in front of it.

Well on its way to becoming a hospital tradition, the crèche is set up each Christmas by Mrs. Thorne, who built it for her own enjoyment and placed it in the hospital that others might share it. The stage is mounted on a stand, banked by lilies and illuminated by two fat red candles set in

star shaped holders of dull gold. The brocades used in the construction of the stage also were obtained in Italy by Mrs. Thorne.

The crèche is actually lighted from the flies of the small stage. The back drop is a yellow-gold brocade. The stage floor is covered with velvet. The scene contains figures of the Christ child, an angel, Mary, Joseph, a shepherd and the three wise men. Camels, sheep, oxen and asses complete the picture. The child is lying in a makeshift crib, on a square of dull blue, a young angel flying over him. The graceful figures and the soft, dull colors blend to form a picture that might have been painted by an old master.

Assignment by Case Method

DOROTHY GARRIGUS KING

NEW practices and procedures intended and designed essentially for large hospitals and for schools of nursing frequently can be modified and adapted for use in the small hospital. This is true of the case method of assignment. This method is not new. Several years ago the outline was suggested in the *American Journal of Nursing* by Mabel Larson. Nurse educators and directors of schools of nursing welcomed this plan which since has become an established factor in ward administration.

An assignment sheet is necessary for written assignments. Types of assignment sheets in use are many and varied, having been planned to meet the individual needs for the departments intended. This particular sheet was originally designed for use in the pediatric department of a large teaching institution. Later it was used successfully in two small hospitals, one having a daily average of 35 patients, the other having a daily average of 20 patients, and both staffed with student and graduate nurses.

The sheet, 20 by 22 inches, is spaced for assignments for nine nurses throughout the period of one week. The left hand column provides space for the name of the nurse and for her special duty assignments. Next, a column is provided for the posting of advance notices. The remainder of the page is spaced for the posting of hours, class hours and daily assignments throughout the week. Before Monday of each week special duties, hours of duty, class hours and notices are blocked in for the coming week. Daily assignments are made out the evening of the preceding day in pencil.

It is important that assignments be kept up to date. Often in the small hospital the entire working schedule is affected by a delivery, an emergency operation or perhaps by the admission or release of one or more patients. At the end of the week the assignment sheet presents

an accurate and concise picture of department or house activities.

In the case method of assignment each nurse is assigned a group of patients for whose care she is entirely responsible during her stay on duty. She sees her patient as an entity and this stimulates her interest in the patient. She realizes that her efforts are partially responsible for the patient's recovery. A student nurse has compared this method of nursing to the making of a dress in which one

Assignment sheets are used at Methodist Episcopal Hospital at Princeton, Ind., to provide an outline for the day's program and to prevent confusion and overlapping of ward duties

person is responsible for its completion, while the divided service to the patient represents a factory made garment in which several persons have a part in its making and no certain individual visualizes the completed garment.

Advantages of the case method of assignment are unlimited. Student nurse, staff nurse, head nurse, supervisor, patient and, in the small hospital, the superintendent, each benefits directly from its use. Opinions concerning advantages of the assignment sheet were solicited from student nurses, staff nurses, head nurses and supervisors.

Evaluations and comments from student and staff nurses included the following points:

1. Assignments are definite and each nurse clearly understands her exact responsibility.

2. The plan provides an opportunity for complete nursing care to assigned patients.

3. The nurse is enabled to give more studied, comprehensive and detailed care to the individual patient.

4. Quality of nursing service is improved since the nurse gives continued care to the same group of patients throughout the week.

5. The nurse learns to refer to the patient by name rather than by room number.

6. Advance posting of hours, classes and patient assignments provide an opportunity for the nurse to plan both for her work and for her leisure.

7. The method furnishes an accurate reference for the student in keeping her case records.

8. The patient receives more individual and effective care and is not upset by a constant change of nurses.

Head nurses and supervisors commented on the plan and its advantages as follows:

1. The method enables the head nurse, supervisor or administrator to equalize the nursing load.

2. It enables her to provide an even division of on and off duty hours for her nursing staff.

3. More thought can be given to the individual patient's needs.

4. The plan affords opportunity for analysis of the nursing care required for each patient.

5. The supervisor is better able to evaluate speed and efficiency of her staff.

6. Nurses on duty can be located without delay.

7. The plan provides a check system in the execution of doctors' orders and nursing procedures.

8. It allows time for ward teaching.

9. It serves as a reference when computing time and service records for students.

10. The plan definitely places responsibility and also serves as a control for the department or the entire hospital.

The case method of assignment is not unlike job analysis advocated

ASSIGNMENTS		14th METHODIST EPISCOPAL HOSPITAL, Princeton, Indiana					
		13th	14th	15th	16th	17th	18th
NURSE AND SPECIAL WORK		DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Miss Gorman (Relief)		3-11	3-11	3-11	3-11	3-11	7-11 P.M.
I Supply) and) Closet 1st Floor Linen)		CLASSES	1-2 (Call)	(Call)	1-2 (Call)	(Call)	1-2
II Make Surgery Supplies			Receive Report Relieve Miss Bolds 3 P.M. 1st Floor & Nursery 3-4 Thermometer Count 4-7 P.M. # 1 Mrs. Bottom # 3 Mrs. Drago # 5 Miss Miller # 6 Mr. Woods Evening Diet 5:30 Dinner 7-11 P.M. 1st Floor & Nursery	Receive Report Relieve Miss Bannister 3 P.M. 1st Floor & Nursery 3-4 Thermometer Count 4-7 P.M. Nursery Mrs. Jones (labor room) Scrub for Delivery 7-11 P.M. 1st Floor & Nursery	Receive Report Relieve Miss Young 3 P.M. 1st Floor & Nursery 3-4 Thermometer Count 4-7 P.M. # 1 Mrs. Bottom # 3 Mrs. Drago # 5 Miss Miller # 6 Mr. Woods Admit Miss Bertram to # 1 Evening Diet 5:30 Dinner 7-11 P.M. 1st Floor & Nursery	Receive Report Relieve Miss Young 3 P.M. 1st Floor & Nursery 3-4 Thermometer Count 4-7 P.M. Nursery # (Mrs. Hayes # 2 (Mrs. Slade # (Mrs. Jones 5 O'Clock Dinner 7-11 P.M. 1st Floor & Nursery	Delivery Scrub 3 A. M. Receive Report 1st Floor) #) 7-11 P.M. Nursery)
Miss Bannister		HOURS	7-12 4-7	7-12	7-12 4-7	6-12	
I Nursery Trays a Bath b Formula		CLASSES	1-2		1-2		
II Nursery Equipment			Nursery Formula 12 O'Clock Lunch 4-7 P.M. Same as A. M. and (Mrs. Hayes # 2 (Mrs. Slade (Mrs. Simmons 5 O'Clock Dinner	Nursery Formula 11:30 Lunch Relieve Miss Bolds) 12:00 (Miss Young) 1st Floor) # 12 to 3 P. M. Nursery)	Nursery Formula 4-7 P.M. Same as A. M. and (Mrs. Slade # 2 (Mrs. Jones (Mrs. Hayes 5 O'Clock Dinner	Early A. M. Care 1st Floor 7:30 Breakfast Nursery Formula 11:30 Lunch Relieve Miss Bolds) 12:00 Miss Young) 1st Floor & Nursery 12-3	
Miss Bolds		HOURS	7-12	7-12 4-7	6-12	7-12	7-12 4-7
I Utility Room a. Hypodermic Tray b. Solutions c. Utility Cabinet 1. Trays 2. Supplies		CLASSES	1-2		1-2		
Note: Make fresh 5% lysol solution for forceps jar each morning.			A. M. Diets # 1 Mrs. Bottom # 3 Mrs. Drago # 5 Miss Miller 11:30 Lunch Relieve Miss Bannister) 12:00 Miss Young) 1st Floor & Nursery 12-3	A. M. & Noon Diets # 1 Mrs. Bottom # 3 Mrs. Drago # 5 Miss Miller 4-7 P. M. Same as A. M. and # 6 Mr. Woods 5 O'Clock Dinner	Early A. M. Care 1st Floor 7:30 Breakfast # 1 Mrs. Bottom # 3 Mrs. Drago # 5 Miss Miller (To be released at 2 P.M.) # 5 Miss Miller Noon Diets	# 1 (Mrs. Bottom (Miss Bertram (To surgery at 8:30 A. M.) # 5 Miss Miller 4-7 P.M. Same as A. M. and # 6 Mr. Woods Evening Diets 5:30 Dinner	A. M. & Evening Diets # 1 (Mrs. Bottom (Miss Bertram (Miss Bertram # 5 Miss Carter # 5 Miss Miller 4-7 P.M. Same as A. M. and # 6 Mr. Woods
Miss Young		HOURS	6-12	7-12 4-7	7-3	7-3	7-12 4-7
I Perineal Dressing Carriage		CLASSES	1-2		1-2		
II Breast Trays			Early A. M. Care 1st Floor 7:30 Breakfast # 2 (Mrs. Hayes (Mrs. Slade (Mrs. Jones (Mrs. Simmons Noon Diets 12 O'Clock Lunch	(Mrs. Hayes # 2 (Mrs. Slade (Mrs. Jones (To be released at 2:30 P.M.) 4-7 P. M. Same as A. M. Relieve in Nursery until Miss Gorman is finished in delivery room. Evening Diets	(Mrs. Hayes # 2 (Mrs. Slade (Mrs. Jones 11:30 Lunch Relieve Miss Bannister) at Miss Bolds) 12:00 1st Floor & Nursery 12-3 P.M.	(Mrs. Hayes # 2 (Mrs. Slade (Mrs. Jones 11:30 Lunch Relieve Miss Bannister) at Miss Bolds) 12:00 1st Floor & Nursery 12-3 P.M.	(Mrs. Hayes # 2 (Mrs. Slade (Mrs. Jones (Mrs. Reynolds 4-7 P. M. Same as A. M. and Nursery
Miss Ackinson		HOURS	7-12 4-7	7-3	7-12 4-7	7-12 4-7	7-3
I Medicine Room a. Hypodermic Tray b. Cabinets 1. Medicine 2. Solutions		CLASSES	1-2		1-2		
Note: Check Drugs each A.M. Make fresh 5% lysol solution for forceps jar each A. M.			A. M. & Noon Diets (Mrs. Simon # 2 (Miss Call (Miss Latham 12:00 O'Clock Lunch 4-7 P.M. Same as A. M. 5 O'Clock Dinner	A. M. Diets (Mrs. Simon # 21 (Miss Call (Miss Latham 11:30 Lunch Relieve Miss Schafer) Miss Butler) at 12:00 2nd & 3rd Floors 12-3	A. M. and Noon Diets (Mrs. Simon # 21 (Miss Call (Miss Latham 4-7 P.M. Same as A. M. and # 23 Mrs. Reid # 31 Mrs. Auberry 5 O'Clock Dinner Feed Mr. Auberry 5:30	A. M. and Noon Diets (Mrs. Simon # 21 (Miss Call (Miss Latham 4-7 P. M. same as A. M. and # 23 Mrs. Reid # 31 Mrs. Auberry 5:30 Dinner 7-11 P.M. 2nd & 3rd Floors	A. M. Diets (Mrs. Simon # 21 (Miss Call (Miss Latham 11:30 Lunch Relieve Miss Schafer Miss Butler) 12: 2nd & 3rd Floors 12-3
Miss Schafer		HOURS	7-12 4-7	6-12	7-12 4-7	7-3	7-12 4-7
I Surgery work room a. Work Table b. Cabinets 1. Supplies 2. Intravenous Solutions 3. Trays		CLASSES	1-2 (A. M., Noon		1-2		
Note: Keep on shelves 6 flasks of each type of solution			Feed Mr. Auberry (A. M.) (Mr. Auberry # 22 (Mr. French (Johnny Elliott 12 O'Clock Lunch 4-7 P.M. same as A. M. 5 O'Clock Dinner	Early A. M. Care 2nd & 3rd 7:30 Breakfast (Mr. Auberry # 22 (Mr. French (Johnny Elliott # 22 (Mr. French (Johnny Elliott Feed Mr. Auberry (A. M.) (Mr. French (Johnny Elliott (Noon	Receive Report Relieve Miss Butler @ 3:00 2nd & 3rd Floors 3-4 P.M. Thermometer Count 4-7 P.M. (Johnny Elliott # 22 (Mr. French (Mr. Auberry (Mr. French Evening Diets 5:30 Dinner 7-11 P.M. 2nd & 3rd Floors	A. M. Diets (Mr. Auberry # 22 (Mr. French (Mr. French (Johnny Elliott (to be released 11 A.M.) 11:30 Lunch Relieve Miss Butler) at 12: Miss Ackinson) 2nd & 3rd Floors 12-3 P.M.	A. M. & Noon Diets (Mr. Auberry # 22 (Mr. French (Mr. French (Mr. French 4-7 P.M. Same as A.M. and # 31 Mrs. Auberry
Miss Butler		HOURS	7-3	7-12 4-7	7-3	7-12 4-7	6-12
I Utility Room (2nd floor) a. Solutions b. Utility Cabinet 1. Trays 2. Supplies		CLASSES	1-2		1-2		
Note: Make fresh 5% lysol solution for forceps jar each A. M.			A.M. Diets # 23 Mrs. Reid # 25 Mr. Nance # 31 Mrs. Auberry 11:30 Lunch Relieve Miss Ackinson Relieve Miss Schafer) 12:00 2nd & 3rd floors 12-3	A. M. & Noon Diets # 23 Mrs. Reid # 25 Mr. Nance # 31 Mrs. Auberry 4-7 P.M. Same as A. M. 5:00 Dinner Feed Mr. Auberry 5:30	A. M. Diets # 23 Mrs. Reid # 25 Mr. Nance (transfer to # 22 after bath) # 31 Mrs. Auberry 11:30 Lunch Relieve Miss Ackinson Miss Ball) 12: 2nd & 3rd floors 12-3 P.M.	A. M. & Noon Diets # 23 Mrs. Reid # 25 Mr. Nance (To surgery @ 9 A. M.) # 31 Mrs. Auberry 4-7 P. M. Same as A. M.	Early A. M. Care 2nd & 3 7:30 Breakfast # 23 Mrs. Reid # 25 Mrs. Perry # 31 Mrs. Auberry Noon Diets
Miss Ball (relief)		HOURS	3-11	3-11	7-12	3-11	3-11
I Blanket) and) Closet 2nd Floor Supply)		CLASSES	1-2		1-2		1-2 (Call)
II Clothes Room			Receive Report Relieve Miss Butler @ 3:00 2nd & 3rd Floors 3-4 Thermometer Count 4-7 P.M. # 23 Mrs. Reid # 25 Mr. Nance # 31 Mrs. Auberry Evening Diets 5:30 Dinner 7-11 P.M. 2nd & 3rd Floors	Receive Report Relieve Miss Ackinson 3 P.M. 2nd & 3rd Floors 3-4 P.M. Thermometer Count 4-7 P.M. # 22 (Mr. Auberry (Mr. French (Johnny Elliott	A. M. & Noon Diets Special Work for Miss Schafer # 22 (Mr. Auberry (Mr. French (Johnny Elliott	Receive Report Relieve Miss Schafer @ 3 P.M. 2nd & 3rd Floors 3-4 Thermometer Count 4-7 P.M. (Mr. Auberry # 22 (Mr. French (Mr. French Evening Diets 7-11 P.M. 2nd & 3rd Floors	Receive Report Relieve Miss Ackinson @ 3 2nd & 3rd Floors 3-4 Thermometer Count 4-7 PM # 21 (Mrs. Simon (Miss Call (Miss Latham # 23 Mrs. Reid Evening Diets 5:30 Dinner 7-11 P.M. 2nd & 3rd
Miss Crider (Night Duty)		HOURS	11-7 P.M.	11-7 P.M.	11-7 P.M.	11-7 P.M.	11-7 P.M.
I Drug) Supply and) Cabinets Stationery) on Landing		CLASSES	1-2		1-2		1-2
II Desks			Receive Report All Floors) # 11 P.M. to 6 A.M. Nursery) 6 A.M. to 7 A.M. Early A.M. Care 1st Floor	Receive Report All Floors) # 11 P.M. to 6 A.M. Nursery) 6 A.M. to 7 A.M. Early A. M. Care 2nd & 3rd floors	Receive Report All Floors) # 11 P.M. to 6 AM Nursery) 6 A.M. to 7 A.M. Early A. M. Care 2nd & 3rd floors	Receive Report All Floors) # 11 P.M. to 6 AM Nursery) 6 A.M. to 7 A. M. Early A. M. Care 1st Floor	Receive Report All Floors) # 11PM to 6 AM Nursery) 6 A.M. to 7 A.M. Early A. M. Care 1st Floor

An assignment sheet for five days of the week. Duties for Saturday and Sunday have not been posted. In the left hand column is space for the name of the nurse and for her special duty assignments.

by those attempting to obtain a more comprehensive program for the management of hospital employees. It applies in the same fashion to the nursing group, providing a definite, well-planned pattern or guide for the

day's program and eliminating overlapping of duties, confusion, waste in steps, energy and time. Through this means adequate, individual and satisfactory care can be assured the patient.



1 The prospective mother and father arrive at Peralta Hospital. Location of the room in the maternity department that has been reserved several weeks previously is given by the nurse at the information desk.



2 After a physical examination by the resident physician, the patient has her temperature taken.



3 Blood counts are a necessary preliminary to the accouchement and are made upon admission. Using a pipette, a few drops of blood are drawn from the patient's ear by the technician from the clinical laboratory.



4 The blood then is taken to the laboratory and spread on slides for viewing under the microscope in order to determine the blood count. Other routine tests are run if these have not been done previously.



5 A cesarean section is the procedure decided upon after a consultation of obstetricians. Before entering the delivery room aseptic technic requires the surgeon to scrub hands and forearms thoroughly.

Movie Portrays

"THE modern hospital stands beside the college, the church and major business organizations as one of the most important institutions in the service to humanity," says the introduction to the motion picture, "Behind the Scenes in the Modern Hospital."

Prepared at Peralta Hospital, Oakland, Calif., primarily to give employees of the hospital some understanding of how the complex hospital organization fits together, the film portrays the entire course of a patient's trip through the hospital. The two reels are in color and can be shown in thirty minutes.

Beginning with a patient's admission, successive scenes show her receiving a physical examination, a blood count and other routine procedures. Filmed also is the x-ray examination and the conference of physicians following it, which result in a decision to perform a cesarean section; the actual delivery of the



6 Moments pass slowly as the anxious husband paces the floor outside the delivery room and waits for news.



7 All linens and dressings used in the care of the new-born infant and its mother are sterilized before using. The nurse is loading one of a battery of autoclaves with bundles of unsterile bandages.

Patient's Progress

GEORGE U. WOOD

baby; the care and treatment of the new-born infant, including identification, weighing, measuring, oiling, treatment of the cord and of the eyes. The aseptic technic used in the preparation of the infant's formula also is included. Incidentally, the patient pictured is a real patient and had a real baby via the route made famous by Julius Caesar.

The film has been carefully edited so as to be of general value to hospitals in all parts of the country for showing either to employees or to public groups. The section showing the actual delivery of the baby has, however, been abbreviated in the version of the film that will be supplied for general audiences. Arrangements are now under way to make the film available to other hospitals. It has been approved by the American College of Surgeons and is dedicated to the American College of Hospital Administrators.



8 Little personal services are remembered and appreciated by the patient. To start the day right coffee is served before breakfast by a piquant Chinese girl wearing a turquoise blue mandarin costume.



9 The attending obstetrician dictates the patient's history to the record librarian. The chart gives all data regarding the cesarean section. The film shows a completed history chart ready for the file.



10 Holding her baby, warmly wrapped in its new blankets and dressed for the first time in its own layette, the happy mother is wheeled to the hospital entrance, with the attentive father hovering near.



Admitting Unit for a Children's

WILLIAM H. SCOPES and

THE new admitting unit at the Tuberculosis Preventorium for Children at Farmingdale, N. J., replaces a building that has served the same purpose as the new structure since the preventorium was established in 1909. The older building, something of a makeshift at the outset, was found inadequate to meet the steadily increased demands made upon the preventorium and the erection of a new unit was decided upon by the directors of the institution.

The problem for the architects was to design a simple, self-contained, easily administered unit to receive approximately 56 children of both

sexes. This unit must permit the children to be housed under careful supervision for a period of about two weeks before sending them to the main preventorium a short distance away. At the main building they would associate with other children for the duration of their stay in the preventorium, which usually lasts from three to six months.

The architects endeavored to separate the children's quarters as much as possible from the administrative portion of the building, principally for the purpose of minimizing the

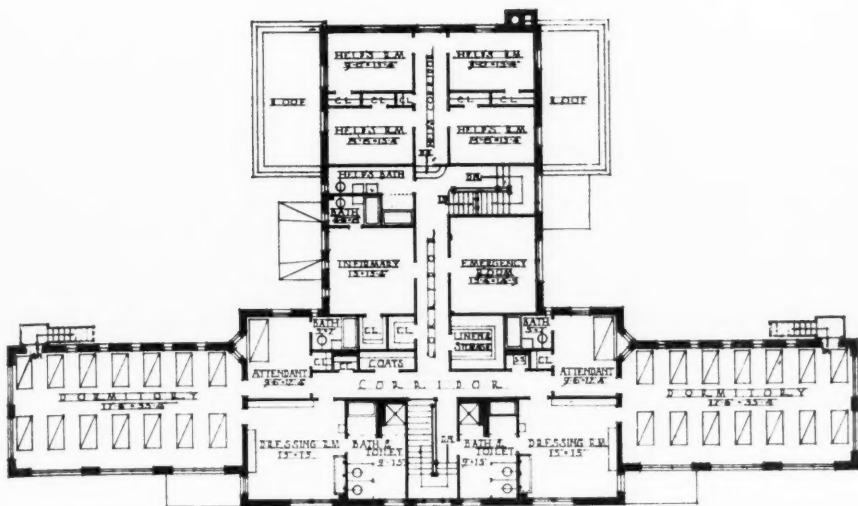
tracking of stairs and corridors, always a problem where active children are concerned. Except when the children go for their meals and diets, their presence in the administrative part of the building is required only on special occasions.

In referring to the floor plans, it will be noted that the first and second floors are practically identical. Four dormitories are provided, each accommodating 14 children. These dormitories are not heated but are entirely protected against storm by means of metal casement sash swinging out on two sides of the dormitories. The openings at the rear are high up windows of the barn ventilator type, hinged at the bottom to swing in at an angle of 30 degrees to the vertical. The sash, when opened, rests on galvanized iron cheeks attached to the sides of the frame, so as to deflect the air upward away from the beds for the purpose of avoiding draughts.

Each dormitory has its own dressing room, bath and toilet rooms. Washing is done at a continuous lavatory having three sets of mixing faucets. There are no plugs to these sinks; the children wash in running water. A drinking fountain is also provided in each dressing room. Shelves with hooks under them have



First floor plan of the admitting unit of the Tuberculosis Preventorium.



Preventorium

MAURICE M. FEUSTMANN

Above: Second floor plan. Note the triangular "lookout" in the attendants' rooms so that they may observe activities in the dormitories without leaving their desks.

been installed where indicated. Outer garments are kept in the vented closets. All other clothing in daily use is hung on hooks under the shelves, so as to be in constant view.

Children occupying the first floor dormitories have direct access to their respective dressing rooms. Those occupying the second story dormitories use the stairs at the children's entrance. The segregation of

sexes is vertical. Children having need of toilet facilities during play time use the bathrooms on the first floor, so as to avoid mounting the stairs. Under the staircase at the children's entrance is a closet for over-shoes for the use of upstairs children, the purpose being to reduce the tracking up of the children's stairs.

Attendants' rooms are adjacent to and connected with each dormitory. Triangular "lookouts" afford additional light and ventilation for the bedrooms but, above all, permit the attendant to observe the activities in the dormitories at all times without leaving the room. The attendant also is near the dressing room, baths and toilets, so as to see what is going on in those rooms as well.

The first floor examining room near the principal entrance is used by the visiting doctor (there is no intern at the preventorium) who goes over the children soon after arrival. Children usually are received in groups. The intradermal tuber-



Barn type windows are set high in one wall of the dormitory to give adequate ventilation without draughts. Kitchen tables and equipment are of stainless metal.

culin test ordinarily has been applied to the children some time before their arrival at Farmingdale by the proper authorities in New York and New Jersey, New York City and the counties of New Jersey that send children to the institution. For admission the child must have responded positively to the test. However, if the physical examination by the visiting doctor discloses an open case of tuberculosis, the child must be cared

for elsewhere as the institution is a preventorium, not a sanatorium.

On the second floor is a small infirmary, with bath, to take care of minor ailments. The emergency room across the corridor is provided to meet any unlooked for situation.

The women employes have their rooms and baths on the second floor. The fireman and houseman have been given quarters in the basement.

A small existing structure situated a few steps from the new unit serves as a playroom in bad weather.

Cost of the preventorium is estimated at approximately \$1100 per

child. In summarizing the construction of the unit salient points specified by the contract are presented. The building is of fire-resistive type. The exterior superstructure is of cinder concrete blocks, stuccoed on the outside, furred on the inside and lathed and plastered. All floor joists are metal and all girders are steel; interior studs are metal; all plaster lath is fire resistive.

The roof is of slow burning, heavy timber type, covered with heavy plank and slate. All staircases are of steel with slate treads. Bath and toilet rooms, kitchen and pantry

have tile floors and washroom walls are tiled to the height of 5 feet.

Lightweight linoleum wainscoting to a height of about 5 feet has been applied to the plaster walls in the main dining room, in the children's dressing rooms, in all corridors, in the waiting room and up the staircases. The following rooms have hardwood floors: dormitories, attendants' bedrooms and employes' bedrooms. Battleship linoleum, 3/16 inch thick, has been applied over wood flooring in both dining rooms, in the waiting room, in the examining room and in the corridors.

Preserving Breast Milk

MARCUS D. KOGEL, M.D.

SINCE April 1937 the pediatric service of Queens General Hospital, Jamaica, Long Island, N. Y., has been using breast milk collected from mothers on the obstetric wards of the hospital and preserved by a simple method of pasteurization and refrigeration.

Breast milk is collected from mothers having an abundance of milk, beginning four days postpartum. No more than 2 ounces is taken from any mother per day. No milk is taken from mothers whose babies have been losing weight or who are not gaining enough. Milk from luetic mothers is given to their own babies and to no others.

Seven ounces of the pooled milk mixed with ½ ounce of sterile water is placed in each of a number of ordinary 8 ounce formula bottles. Sterile corks are placed lightly in the bottles so that they will not blow out when the milk is heated. Over each of the corks are placed six layers of sterile gauze, a large piece of cotton and finally a piece of sterile waxed paper. Surprisingly enough, waxed paper can be autoclaved. This covering is held in place by a rubber band.

Bottles are placed in a bottle rack, which is placed in the top of a double boiler on a wire mat in cold water that reaches to the level of the milk in the bottles. The water is maintained at a temperature of 175° to

180°F. for thirty minutes with the flame turned off. Precautions must be taken so that the milk will not be overheated, because it will caramelize.

Bottles are then kept for twenty-four hours at room temperature. The process is repeated at the end of this time and repeated again at the end of forty-eight hours. Following the third heating the corks are tightened in the bottles, the coverings are removed and the corks are sealed with several coatings of paraffin so that they are air tight. Bottles are refrigerated at a temperature between 38° and 52° F.

When an immediate need for the milk arises, it is only pasteurized once. After the first heating, it is cooled at room temperature and stored in the refrigerator.

To date this milk has been used on 66 babies, the majority of whom are premature. The largest quantity received by any one baby was 480 ounces over a period of three months. There have been no reactions resulting from its use.

The longest period the milk has been preserved before use is two and a half months. There has been no occasion to keep it longer, although it has been claimed that the milk will keep from one to two years. Single pasteurized milk is not kept

for more than forty-eight hours. The only change occurring after standing for a few days is the rise of the fat to the top of the bottle.

Of the 5771 ounces preserved between April 1937 and June 1938, approximately 50 per cent was triple pasteurized and the other half was pasteurized once. Breast milk sells for 25 cents an ounce; if the hospital had purchased this milk, it would have cost \$1442.75.

This quantity of milk was collected despite the following handicaps: (1) a relatively small obstetric service having an average daily census of forty-five; (2) the restricted quantity of milk available from mothers in the vicinity of the hospital; (3) refusal of many mothers to have their breasts pumped, and (4) the fact that breasts of mothers who do not wish to nurse their babies must be permitted to dry up.

The hospital has made no attempt to interest outside mothers in donating milk for preservation. If this were done it would provide enough milk for all needs of a pediatric service in many communities.

This method of preservation is economical, safe and convenient and can be carried out in cases in which only ordinary icebox or brine refrigeration is available.

Designed for Premature Infants



ASA S. BACON

A NEW nursery for premature infants was opened recently by the Presbyterian Hospital, Chicago. This nursery is equipped to provide the basis for a sound nursing technic.

Each infant in the nursery is housed in a completely enclosed air conditioned cubicle of a type developed at Presbyterian Hospital and recently put on the market. Each cubicle is made of steel and shatter-proof glass.

Individual equipment is provided in each cubicle for full care of the infant and no infant need ever be removed from a cubicle until it is ready to go home. There are gowns and masks for doctor and nurse, weighing pans, foot controlled wash-bowls, waste receptacles, piped oxygen connections, a thermometer, electric lights, a crib table, shelves



Top: Three of the seven completely enclosed and air conditioned cubicles that recently have been installed at Presbyterian Hospital, Chicago. Air escapes through the ventilator outlet (1); heat is controlled by the thermostat (2) and is indicated by wet and dry bulb thermometers (3); oxygen intake is controlled by the oxygen jet and flow meter (4); air enters through the inlet (5) and moisture is controlled by the humidistat (6).

and all other necessary equipment in each cubicle. Equipment used for one infant is never used for another until it has been sterilized.

We have mounted the scales on a small truck and provided separate weighing pans for each infant. This truck is wheeled into each of the cubicles in turn so that no infant need be taken from the cubicle for weighing.

A master air conditioner brings filtered humidified and warmed air to each cubicle. An individual electric heating unit is imbedded in the ventilating duct over each cubicle so that the temperature of each can be maintained by thermostatic control at any level required from room temperature up to 95°F. One cubicle can be raised to 105°F. Part of the air circulated to the babies is drawn from out-of-doors and part recirculated from the room. Humidification is accomplished by a water spray controlled by a humidistat in one of the cubicles.

In order to reduce the likelihood of air-borne infection an ultraviolet light probably will be installed in the air duct after certain tests have been completed.

The air coming into each cubicle will escape through a small opening in the cubicle door near the floor. Thus air will be constantly leaving the cubicle and very little air will enter. However, to prevent any air that might occasionally come from the corridor into the anteroom from carrying germs into the cubicles, another ultraviolet light is placed over the door separating the anteroom from the nursery.

Two nurses are on duty at all times to care for the seven premature infants housed here. This means a shift of six nurses during the twenty-four hours. In addition, the chief of the division, one member of the attending staff, one resident and one intern are permitted to enter this nursery. Aside from these six nurses and four doctors, no one is permitted inside. A window in the door on the corridor gives parents an opportunity to see their children in the cubicles.

The cubicles have been placed a sufficient distance from the wall so that plumbers and electricians can have access to the wiring and pipe to make repairs.

While this department has been designed only for premature babies, we see no reason why the same sys-

tem would not also be desirable for other infants, particularly those that have become infected.

X-Ray Department Modernized

WITH the installation of a powerful new diagnostic x-ray generating unit, the Leila Y. Post Montgomery Hospital, Battle Creek, Mich., completes a comprehensive modernization program inaugurated four years ago to provide for its patients electromedical facilities of the most complete and up-to-date type.

The final step in the program under immediate consideration was the installation of the newest kind of rotating anode x-ray tube. It was the first tube of its type to be purchased in Michigan.

Beginning with the installation four years ago of high voltage deep therapy equipment with special desk control, the modernization program has gone steadily forward. This high-powered x-ray therapy installation includes a modern shockproof tube stand to provide complete electrical safety both to patient and operator, built-in x-ray dosage measurement instruments and a specially designed and constructed motor driven table which makes treatment possible in almost any position.

In addition, Leila Hospital has arranged to keep a sufficient quantity of radium on hand to be used in conjunction with the deep therapy treatment when it is required.

Arrangements also have been made to provide the simplest possible means of giving superficial x-ray therapy at lower voltages without disturbing any of the other equipment in the x-ray department. Plans are limited in scope only by the capacity of the second therapy tube unit which relieves other equipment of additional load.

A modern type of x-ray table has been installed in the diagnostic room to provide all necessary facilities for fluoroscopic and radiographic techniques. The diagnostic department, located directly across the hall from the therapy section, includes new x-ray darkroom equipment. This

will make possible faster and more efficient handling of x-ray films.

From the main high-voltage x-ray transformer, connections are made to provide x-ray examination facilities in the cystoscopic room. A new fracture table, which allows the medical staff to employ the most advanced technics in fracture reduction, has been provided with a mobile shockproof x-ray unit so that the progress of bone manipulation may be under constant observation. The same x-ray unit may be moved into rooms.

Old type diathermy machines have been replaced by new machines that generate heat deep in the human body tissues by electromagnetic induction, a method found highly successful when more than superficial heat treatment is required. With these new devices, it is possible to give not only localized treatment of joints and other limited areas but also complete fever therapy.

The rotating anode tube, which adds the final touch of modernity to the hospital's diagnostic facilities, has several features that set it apart. It has two focal spots for use selectively, the smaller of which is the smallest focus incorporated in a commercially available hot-cathode x-ray tube. The larger spot, being only 2 millimeters square, is only slightly greater in area than the smallest focal spot available in tubes of the conventional type. The size of the focal spot is of tremendous importance to us because the sharpness of detail on our x-ray films depends to a large extent upon focal spot size: the smaller the spot, the sharper the picture it is possible to get.

Because of the principle of anode rotation which spreads electron bombardment over a large area while the effective focus of the tube remains small, this tube permits the use of the very heavy currents for high speed exposures of heavy and other parts of the body difficult to be radiographed.

BORIS FINGERHOOD, F.A.C.H.A.

This joint committee delegated me, as chairman, to look into the problem and report my recommendations. Effort was concentrated on working out a plan that would combat the existing evils. It was evident that a simple yet complete system of checking the requirements in connection with transfusions was needed. Study of the situation revealed that it would be necessary to install in every hospital a definite system of recording reactions, both before and after the transfusion. There also appeared to be need for keeping a register that would be open to inspection from every possible angle and that would serve as the key to all the checkings of the individual forms.

The requisition for transfusion and the record of transfusion, which for purposes of ready identification

to Cashier
Transfusion Voucher No. _____

Please Pay To _____
For Patient _____
Chart No. _____ Location _____
Sum _____ Dollars
for _____ c.c. to be used.
Requisition No. _____

_____ Admitting Office

\$ _____ Date _____

(2)

.....
(From Cashier to O.R.)
Patient _____ Number _____

Please record in Transfusion Register for Requisition
Number _____
Donor's Name _____
c.c. used _____ Amount Paid \$ _____
Received by _____
Date _____

It should be noted that the record of transfusion, which becomes part of the chart, calls for information that makes it necessary for those in charge of the transfusion to look out for a number of essential requirements. It provides for ascertaining,

A brief record of each transfusion is entered in the register, which usually is kept by the operating room supervisor or laboratory technician.

NAME OF HOSPITAL
TRANSFUSION REGISTER

[illegible]

RECORD OF TRANSFUSION

Date _____ Page Number _____

Patient _____ Admission No. _____ Location _____

Age _____ Sex _____

Diagnosis _____

Indication _____ Previous Transfusions: Dates _____

Patient's Type _____ System Used _____

Typed By _____ When _____

Professional Donor's Name _____ Address _____ No. _____

Name of Agency _____

Family Donor's Name _____ Relationship _____

Donor's Type _____ System Used _____

Typed By _____ When _____

Crossmatching: By Whom _____ When _____ Rechecked By _____

Donor's Wassermann Test: Date _____ Hemoglobin _____

Donor's Physical Examination: Date _____ By _____

Donor's Book Inspected: Before Transfusion _____ By _____

Last Transfusion: Date _____ Amount Given _____ cc.

Present Transfusion: Date _____ cc. Used _____

Performed by: Dr. _____ Supervised by: Dr. _____

Injection Begun _____ Completed _____ Nurse _____

Direct Method: Was incision of the vein made? _____ cc. Used _____

Indirect Method: Blood Amount _____ Citrate _____

Glucose _____ Saline _____

Time Blood Drawn _____ a.m. _____ p.m. Time Blood Used _____ a.m. _____ p.m.

Time Blood Kept _____

Reaction to Transfusion _____

Result of Transfusion _____

If Reaction, Apparent Cause _____

If Transfusion Not Given, Contra-indication or Reason _____

Remarks _____

(Signed) _____

(Intern in Charge of Patient)

The record of transfusion (left) requires persons in charge of the transfusion to obtain and classify all necessary information pertaining to the transfusion. For easy identification it is printed on the same color of paper as the transfusion requisition below.

NAME OF HOSPITAL REQUISITION FOR TRANSFUSION

Date _____ Page No. _____

Patient _____ Admission Number _____

Location: Ward _____ Room _____

Requested by Dr. _____ Service _____

Date of Request _____ Hour _____ Urgent _____

Routine _____

Diagnosis _____

Indication _____

Amount of Blood to be given: _____ cc.

(Signed) _____

(Private Patient - Physician in charge)

(Service Patient - Attending on service)

The requisition for transfusion may be made out by the physician in charge and is routed through the office designated by the administrator. With the record of transfusion it is incorporated in the patient's chart.

among other things, whether the blood was typed, the system used in typing, by whom and when typed and, what was found to have been overlooked in a number of instances, information about crossmatching: whether it was done, by whom, when and by whom it was rechecked. It necessitates finding out when the donor's Wassermann test was taken as well as the date of his last physical examination. It also calls for an inspection of the donor's book before transfusion and the recording of his last transfusion.

In the event that a hospital uses blood banks, provision is made for a record showing the time the blood was drawn, the time the blood was used and the time the blood was kept. In short, the record of transfusion, when properly filled out, supplies information which, if left unquestioned, might result in the use of infected donors for transfusions.

The transfusion voucher is to be sent by the admitting office, which collects the money for the donor, to the cashier, who pays the donor and obtains his signature on the transfusion voucher from cashier to operating room (part 2, below perforation). The cashier sends this form to the operating room supervisor for transposition to the transfusion register and it is then sent to the record room to be made part of the patient's chart.

A significant point about the requisition for transfusion is that it makes it imperative to state the indication for the transfusion, something that is frequently lacking in notes on charts with reference to such transfusions. On the other hand, the transfusion voucher providing for payment to the donor for the transfusion contains another significant point in that it specifies definitely the number of cc. used and the amount paid. This

makes it impossible for any discrepancy to occur between the amount charged to the patient and the amount actually paid to the donor, an evil which, as some members of the Kings County Medical Society have pointed out, is frequently indulged in.

The operating room supervisor or someone in the laboratory (by designation of the superintendent) is to keep the transfusion register, on which is specified the requisition number. Inasmuch as the requisition contains the details of a given transfusion, it is not necessary to repeat all the information on the transfusion register. The register is bound in book form and contains an alphabetical index, into which is written the name of each patient to correspond with the index number, which is entered in the second column of the register. Chart, requisition and receipt numbers also are given.

Practical Organization of Staff

JOSEPH C. DOANE, M.D.

THE organization of the hospital staff may appear simple and easy to the uninformed but actually it is a complicated matter. Here a large number of physicians with all types of personality, skill and training must be molded into a frictionless whole that will work toward a common end.

As specialty succeeds specialty, the efficient fabrication of the units comprising the hospital staff becomes increasingly difficult. Indeed, because of their very size some staffs are so cumbersome that they fail to work in an efficient manner.

It was not so formerly. A few decades ago a hospital visiting group, if departmentalized at all, usually consisted of the medical and surgical divisions. The wards contained side by side all types of patients, medical, surgical and the specialties. Staff organization was exceedingly simple, internists taking care of all nonsurgical cases and surgeons treating those requiring general as well as specialty attention. The doctor was then a sort of Jack-of-all-trades.

Then came a separation of both physical facilities and staffs. Even today in small institutions that perform creditable work one may find surgical and medical patients treated side by side, acute and chronic illnesses occupying the same ward.

Indefinite Qualifications

But the qualifications for physicians assigned to these two main divisions were formerly, and are in some instances at present, poorly worked out. The internist was likely to be a physician who practiced family medicine and on request officiated at a delivery or performed a tonsillectomy. He might be an internist on one hospital staff and a surgeon on another in the same community or even combine the two specialties on both. Again he represented somewhat of a hybrid, being an internist on ward service but when he entered the exclusive precincts of the private department being either a surgeon or an internist.

Before the advent of the American College of Physicians and the Board of Internal Medicine internists often were like Topsy, "they just grewed." To become specialists and to become chief on a hospital ward some physicians had only to forego the practice of obstetrics and minor surgery. Too often young physicians were required only to demonstrate the possession of a good clientele, to possess a board friendship or to have married into a wealthy and influential family to reach this eminence.

Surgeons, however, were more likely to have passed through several stages in their development before reaching a full chiefship. They were required to pass through the larva and pupa stages before emerging into the butterfly state of full specialization in surgery. Even then there always existed a great temptation to revert to the ways of an earlier and lower form of life and to treat pneumonias and upper respiratory infections on request or to officiate at a delivery a few times a year.

In all physicians there seems to exist a great reluctance to forego any type of work, even though it conflicts somewhat with the specialty that they propose to practice. The urban physician who endeavors to be both an internist and a surgeon is short sighted to a degree. It is a well-known tendency on the part of young practitioners of medicine to hesitate to call in a surgeon who also practices internal medicine, because of a well-founded fear of losing their patients when the surgical emergency is over. It is impossible from the standpoint of the individual, therefore, as well as inadvisable from the standpoint of the hospital, for staff physicians to be "all things to all men."

The younger surgeon of today by dint of careful preparation, postgraduate work and thorough practical training is more inclined than his older colleagues to announce his

status boldly. He is likely to refuse cases that fall outside his specialty and to rise or fall with his determination to make a living for himself and his family in the practice of his chosen branch of medicine. Such surgeons often rise to greater heights than they who remain hybrids during their formative years. Such physicians represent the material in which the American College of Surgeons and the American Board of Surgery find their best prospects.

To Clarify Hospital Practice

The time is fast approaching when the present confusing picture will become clarified by the development of institutional practice. Hospital boards are more and more becoming convinced that no one human being can become a master of all of the various special branches of medicine to the same degree as can one who devotes his whole time to one specialty. If there is one significant development in staff requirements as interpreted by hospitals in the past decade, it is the insistence upon proved ability in a specialty before chiefships are granted.

In addition to divisions of medicine and surgery, other cleavages have shown themselves. Specialties have crept into the medical department: cardiology, gastro-enterology, metabolism, diseases of the chest and, before these, pediatrics. Neurologic patients seldom are found occupying beds controlled by the medical department. In surgery, the trend toward specialization early became apparent; gynecology, orthopedics, proctology, otolaryngology and, later, chest and brain surgery have taken their place as divisions.

But such ultradepartmentalization was not brought about painlessly. Indeed, in some instances in hospitals of smaller size it is doubtful whether the creation of special departments always tends toward efficiency. In some instances in which beds are not

available or are not required by the number of patients to be treated, specialty departments exist on a consultation basis only. In larger institutions wards are assigned in which such specialty patients are received.

In the course of such cleavage it was natural, since human beings were the units affected, that jealousies should arise. The internists were not happy when metabolism, cardiology and gastro-enterology with their corresponding staffs became recognized as a part of this department. The internist felt that because he was treating diabetes daily in his private practice he was perfectly capable of handling ward patients suffering with this disease. The same argument was put forth for each of the specialties involved.

Preliminary Steps

Before permitting a new specialty division to be created in its staff organization it would be well for hospital boards to make certain that there is a need for such a development and that the physician or physicians assigned thereto actually are specialists in the particular type of work. The argument against overspecialization hardly exists when surgeons and internists are being compared. Here are two types of activity that require not only an entirely different plan of training but also a distinctly varied personality.

The question may well be asked, however, whether cleavages in the surgical department may not be carried too far, whether the development of specialization in the small hospital may not be reduced to an absurdity. The general surgeon finds himself faced with an ever increasing reduction in the type of work that he formerly performed. In many instances he no longer is permitted to treat neurosurgical, gynecologic, orthopedic or proctologic cases on the wards. Perhaps in hospitals of 300 beds and more all of these specialties may find sufficient material from which experience and investigation may be obtained. On the other hand, there are some splendid institutions in the field in which general surgeons perform capably most of the specialties previously enumerated.

The crux of the whole matter lies in the type of individual found on

the general surgical staff and in the thoroughness of the training of these physicians. It certainly would be more advantageous to the hospital to possess a strong, surgical service than a conglomeration of several weaker divisions with poorly trained staff men.

Whatever the staff setup from the intricate specialty organization to the simplest departmental arrangement, there should exist a well conceived plan of interrelationships for all of the component divisions. Each of these divisions should possess its chief or president of staff who presides at monthly conferences and who enjoys the confidence and respect of his colleagues. Any department is as strong as its component divisional organizations. Such an arrangement makes possible meetings for the discussion of common staff policies, for the transmission, receipt and consideration of interdepartmental communications and for carrying out common policies regarding such matters as consultation, ways and means for obtaining a high percentage of postmortem examinations and provision for conducting investigative, scientific and literary work.

If specialty divisions consist of only a few staff men, monthly conferences should probably be held on a departmental basis. Yet it must be conceded that an inspirational and productive staff conference may be held by two well-qualified physicians and a point-less and unproductive conference may be held by a large group.

With such a complicated setup, therefore, one generally finds four departments, each possessing few or many divisions. The medical, surgical, laboratory and obstetric departments are the framework into which as many specialty divisions as are necessary are integrated. The problem that presents itself to the hospital board and its executive is the development of strong teamwork in each staff and among all subdivisions.

In many smaller hospitals mixed staffs exist in which but little attempt at specialization has been made. In a small community it is difficult for a physician to succeed in the practice of surgery alone. But there should be a continued attempt on the part of the small community hospital to develop specialists among the staff

by encouraging postgraduate work, by urging refresher courses and by elevating young men who have demonstrated a particular ability.

Whether the hospital is large or small, whether or not it is departmentalized, it possesses the functions common to all institutions: the care of medical, surgical, obstetric, nose and throat, gynecologic and orthopedic cases, not all of these specialties being represented by any one man or staff.

The staff conference is the liaison activity from which plans for creating proper interstaff relationships may develop. The monthly staff meeting is the place for the discussion of the best methods of performing the work of the specialty that it represents. From the standpoint of the individual patient, however, these meetings represent only an indirect possibility of good, although any activity that improves the efficiency of hospital operation benefits the cause of the patient.

Efficient Consultation

The most important point is to determine directly and quickly how the skill, training and experience of the representatives of the various specialties can be focused upon an individual patient's bed. Herein lies the need for the development of an effective consultation system. The efficiency of any consultation procedure is largely affected by the geography of the hospital under consideration. When medical and surgical wards lie at a great distance from each other, a liaison between these staffs is made relatively more difficult.

Most consultations represent paper contacts, devoid of the fire of personal conversation or of professional combat. Often the emergent need of the patient is passed before red tape can be unraveled and a consensus of medical, surgical or other specialty judgment is obtained. Such lame excuses as that the chief had not come to the hospital, or had left before the consultation request was made, or that the intern forgot to execute the proper form are of little interest to the patient and of little help to his cause. Even if a written consultation is promptly filed there is often a lack of follow-up on the part of the consultant and little attention is paid to

the fact that acute disease is rarely static but is always progressing or receding.

No consultation system, therefore, can be deemed efficient unless it promptly brings the desired information and unless it provides for the personal contact of the physician in charge and his consultant. A consultation should not consist of routine correspondence. A letter may be written acknowledging the presence of a mitral stenosis well compensated but never concerning a case of acute pulmonary edema or of lobar pneumonia with cardiac collapse.

Now as to the method by which a practical application of these principles can be brought about. Every case admitted to the surgical department may be assigned in rotation to the medical chiefs on duty and a medical opinion should be obtained upon the admission of the patient. It is possible to make this procedure apply also to the medical wards so that a dual responsibility exists for the care of each one of these patients.

It is perfectly proper for the hospital to insist that no patient be permitted to go to the operating room for an elective major procedure without a medical opinion being present on the chart. Before operation an electrocardiograph might be considered as a requirement for every case of this kind. In the surgical ward no medical complication should be overlooked by a visiting internist. If the admission office were to supply a card notifying at least two physicians of the entrance of each medical, surgical or pediatric patient, it would be unnecessary to continue consultations by correspondence. Team work of this sort frequently would bring about the presence of the medical consultant in the operating room. It also would result in the attendance of more surgeons and internists at necropsies, a speeding up of surgery or medical treatment in the majority of cases and, no doubt, a laudable slowing down of major surgery on patients with definite cardiac or other serious handicaps.

From the standpoint of consultation a staff is as good as its pliability and as inefficient as its lack of ability to engage in interdepartmental communication and service. No hospital can succeed in rendering a modern

service that allows a harmful autonomy to exist among its staffs. It must develop staff consultation-mindedness, proving thereby that it is no confession of weakness for even the

most skilled of surgeons to ask for a medical opinion or for the most austere internist to request the presence of the surgeon at the bedside of a critical case of typhoid.

Time to Call a Halt

S. S. GOLDWATER, M.D.

ASSUMING that public health administration is now definitely committed to a program of personal medical care, what is the proper instrument for the accomplishment of the end in view? Is it a health center with detached and fragmentary dispensary services ("orphan clinics" without hospital parentage) or is it a perfected hospital, which alone can provide indispensable clinical correlations? In the absence of a sound conception of the essentials of an effective organization for medical care, mistakes are bound to be made.

As an instrument for complete and effective medical service, the prevailing type of general hospital is admittedly imperfect. A hospital may lack essential or fully organized clinical services or an adequate number of trained medical social workers or vigorously conducted follow-up clinics or up-to-date laboratory or therapeutic organization or equipment. An expert rating committee might give to a general hospital of the better class a rating of say from 60 to 80 per cent, depending on the liberality of the committee's ideals. Tested by the same standard, a health center would rate at, shall we say, 5 per cent?

Since existing hospitals lack attainable excellence, let them be improved. A better geographic distribution of hospitals is needed in large cities and in some rural areas; the objective of balanced distribution should be constantly pursued.

In brief, what is needed to accomplish the declared major aim or, at least, one of the preponderant aims of current public health administration is an adequate system of district hospitals. Health centers will not do, for by no stretch of the imagination can the so-called health center furnish complete medical care.

Do I overestimate the danger of the health center program?

There appears to be a definite tendency on the part of public health administration to proceed as follows:

1. Assert the truism that the health of the people is a government duty.
2. Point out that the maintenance of health involves personal medical services.
3. Show that medical service is often inadequate, stressing particularly the alarming inadequacy of diagnostic and therapeutic resources in certain diseases.
4. Establish under public health control new agencies to supply the gaps.
5. As each disease is attacked, create an administrative bureau to direct a program of more adequate care for the particular disease, thus plunging straight into the sea of medical administrative specialism.

The dangers of clinical specialism are well known; those of administrative clinical specialism are not yet clearly apprehended. Only in a comprehensive medically controlled organization of the hospital type can the dangers which are inherent in clinical specialism be checked. Hospital administration has long been aware of this and has been striving for the development of general hospitals in the full sense of the term, in order to fulfill the needs of coordinated or group clinical practice. Yet public health administration moves calmly on toward the creation of a separate administrative bureau for each disease.

The time to call a halt is now, when the process is only beginning. I urge the more complete development of correlated hospital services as a needed corrective and as the proper aim of public health administration today.

Hospital Has Own Scout Troop

MOIR P. TANNER

A BOY scout troop that does its scouting in a hospital—that is boy scout troop No. 144 of Buffalo, N. Y. Its locale is the Children's Hospital of Buffalo.

The troop was originated a year ago. It has aroused the interest of the boys who are patients, the hospital personnel and the community. Members of the scout headquarters staff aided in the organization, assisted in the opening meeting and since then have given their full cooperation to all activities. Thus they have overlooked technicalities* regarding age, chiefly because they can visualize the value of scout training to these youngsters. The advantage is not one-sided, however. Discipline of these youngsters has ceased to be a problem.

As they become familiar with the boy scout creed we find the boys in our troop doing their best to be of as little trouble as possible. Their school work has improved immeasurably.

The other day one of the staff doctors said to a lad: "Well, Dickie, you can go home Tuesday." Instead of the expected glee, the doctor saw two large tears roll down the boy's cheeks as he stammered, "Gee, doc, can't you make it Friday, 'cause scout meeting is on Thursday?"

To many it might appear that a scout would need much wit and ingenuity to find a good turn to do every day in a hospital. But such is not the case. It is amazing how many good turns scout-trained eyes can see to do.

"If you're busy I'll feed Joe," offers a scout as he sees a nurse about to serve a patient who cannot manage alone. Perhaps a comrade is tired and uncomfortable and bored. "I'll read to Pete awhile," offers a scout, alert to do his good turn.

Meetings are held on Thursday nights. Some of the boys wear their scout uniforms and all of them wear scout neckerchiefs. As the meeting



Illnesses are forgotten as these boy scouts listen with rapt attention while exciting adventures are related by aviators, engineers and others.

opens the colors are raised, the court of honor gives examinations and awards merit badges.

A scout who is not able to leave his bed may nevertheless advance right through scouting. He may even become an eagle scout and that isn't such an easy job. In recognition of its difficulty, the title "achievement scouts" has been given to those lads who acquire the handicrafts, tie the knots, learn the woodlore, natural history, science and first aid—all the skills that win merit badges for hospital scouts.

Some special kind of entertainment always is a part of the meeting. Sometimes other scout troops pay a visit and present short programs. Older scouts act as assistant scoutmasters and the proudest leader in our section is the young attorney who is our scoutmaster. He loves every lad and they all take their troubles to him.

Scouting has brought many a glimpse of the outside world to our troop. Firemen, policemen, aviators, a railway engineer and other men having exciting jobs have talked to them. Men prominent in the sports

world are scheduled for the future.

The scout committee is made up of the president of the hospital staff, two other staff men long interested in scout work and the hospital superintendent. It is a great sight to see one of Buffalo's most prominent surgeons work for half an hour with a little colored lad, flat on his back in bed, who cannot get the half-hitch just right.

Boys come and go but the troop continues to grow. Many former members of the troop have been transferred to other troops after they left the hospital; many boys who already were scouts when they came to the hospital continue with their tests. Some boys have been transferred to other hospitals and to convalescent homes and have written to ask that a scout troop be formed in their new quarters.

Our scout troop has opened up a new life for these boys. In the future it seems likely that more troops will be located in places in which boys are cared for. For boys who cannot go out into the world of scouting, this greatest of all boys' organizations can come to them!

New Areas of Voluntary Service

ABRAHAM OSEROFF

THE American people today are hospital minded as never before. There is evidence of tremendous good will toward our hospitals and this mirrors the service communities have learned to expect of their institutions. This good will shows much appreciation for high standards of service maintained in the past. Even more, however, it shows faith in the ability of our hospitals to keep pace with the requirements for the future.

Yet in the 1937 annual census of hospitals by the A.M.A.'s council on medical education and hospitals, of a total of 6128 registered hospitals, only 954 were approved for the training of interns and residents. If it is conceded that the equipment, service and pedagogic approach required by the association for intern approval are essential in setting the standards of an effective and virile hospital picture, how can we justify the fact that only 15 per cent of the hospitals are so rated?

In its 1938 list of approved hospitals the American College of Surgeons included 2664. If it is conceded that the A.C.S. approval standard is no more than a minimum requirement for an effective well-rounded hospital service, how can we justify the fact that little more than one-third of all hospitals in this country reach even this stature?

Plight of Small Hospitals

It is true that smaller institutions in outlying sections, because of the comparative inability of the population to finance adequate hospital construction and equipment and because professional talent can be less readily obtained, find it difficult, even well-nigh impossible, to reach the standards of the recognized hospitals of this country. However, it still remains a fact that, for one reason or another, the majority of our hospitals today have been unable to reach the standards and ideals generally

promulgated by the medical profession and hospitals.

There is much thought and considerable fear of further governmental penetration in the provision of hospital service and its effect on our voluntary system of hospitals. Certainly in localities now not fully serviced it is apparent that governmental interest will be greater than it has been heretofore. Larger payments to voluntary hospitals through local and state and federal units for the hospital care of indigents will necessarily mean a closer type of relationship with governmental bodies and perhaps somewhat closer supervision than heretofore.

Is it not possible however, that fears of impending disaster are considerably exaggerated? It is important that we brush aside some of our preconceived notions based on the past and assure the adaptation of voluntary hospitals to needs as they exist now.

From time immemorial, the philanthropic urge has been a dynamic mainspring in the provision of care for the sick and needy. Experimental science joined hands with philanthropy to build the voluntary hospital. The record of this institution has been enviable. In spite of changes in economic and social points of view, it is folly to believe that either the urge or the resources for philanthropy will completely dry up. It is equal folly for the voluntary hospital to feel that all free service should be paid for out of public funds while these institutions still retain complete voluntary control.

While more of the hospital's free service load may, as the days go on, be financed out of tax funds, there will probably always continue to be a residual percentage of borderline cases feeding the free service section of our voluntary hospitals. Even though this is true, however, probably there will come a decided shift in emphasis from philanthropy as an

important basis of hospital maintenance financing toward voluntary hospital care insurance. Today undue emphasis is placed on philanthropy as a governing force in the provision of hospital care and service. The rapid progress and general acceptance of hospital care insurance plans may change this emphasis.

Low Premium Plans

The number of subscribers covered by these plans doubled during the past year. In the near future the coverage will probably embrace no less than ten million patient consumers of hospital service on the basis of the present typical semi-private room type of contract which appeals primarily to the "white collar" class. Among those who today cannot pay, a considerable number can be lifted to the level of ability to pay through the operation of low premium plans. When we have taken this next step by providing for the low paid factory and mill worker on a ward basis at a proportionately lower cost, it is conservative to estimate a coverage of 15,000,000 additional subscribers in due time. The net income to hospital care insurance plans from this group of 25,000,000 persons should be not less than \$100,000,000 annually.

The Interdepartmental Committee to Coordinate Health and Welfare Activities of the federal government estimated that while in the year 1929 patients themselves paid \$2,890,000,000 in the purchase of health services, philanthropy during that year contributed the sum of \$180,000,000. But in 1936, while patients contributed directly for similar needs the sum of \$2,560,000,000, the contribution of philanthropy had dwindled to the sum of \$60,000,000. As against this contribution by philanthropy, it does not require a vivid imagination to visualize the impact of a \$100,000,000 income from hospital care insurance.

Another recent factor should be stressed. The American Hospital Association at its 1938 session passed

a resolution "concerning the principles of relationship between approved hospital service associations and the medical profession in proposals to provide medical service on an insurance basis to hospital patients of limited income." This offered cooperation between approved hospital care insurance plans and local medical societies wishing to provide medical service on an insurance basis.

The *Journal of the American Medical Association*, in its issue of Oct. 15, 1938, said: "It is encouraging to have such a statement from the leaders in the field of the hospital, since the hospital is today a center of medical service. The action taken by both the American Medical Association and the American Hospital Association now permits the establishment of cooperative plans for group payment for medical service without invalidating any of those ideals or principles associated with medical care which are vital to the provision of good medical service."

Adapted to Fit Needs

Thus the key forces in the provision of medical and hospital care have indicated a willingness to pool their resources of experience and skill to enable our present voluntary structure to meet effectively the needs of our people.

So much for the general trend from philanthropy to self-respecting insurance payments.

But there are other and more concrete influences on hospitals that are clearly apparent. Perhaps one of the greatest results will be the building of hospital facilities in direct ratio against known community needs rather than under the stimulus of individual, sometimes paternalistic, interest. This is not to decry the tremendous contribution made by those who have promoted, built and endowed institutions for philanthropic motives. Achievement in the hospital field would have been negligible without this important interest. But in its wake have come duplication and overlapping that under present economic pressure must be removed if we are to supply needed hospital and medical care upon a basis which communities can afford. Central fund pressure should develop in-

terest toward coordination of hospital activities, both voluntary and governmental, to avoid duplication of plant and management costs.

Unified action should also lead to a type of cost accounting more practically adapted to present day hospital requirements. Costs of various services provided in the hospital should be determined with reasonable accuracy. Rarely is this true today. The label, "pay facilities," should carry with it a definition in accord with the meaning of the term so that contributors who are asked to serve the poor are not in reality submitting to a subsidization of payment for facilities used by those able to pay. Conversely, accurate cost accounting can eliminate the ill will created through higher charges than are warranted for some pay services, thus indirectly forcing from individuals, without their knowledge or against their will, contributions to meet losses on other services.

Because the hospital is surrounded with a halo of personal service and sacrifice in ministering to the sick, hospital employees continue to be segregated into a separate class.

There seems to be no valid reason for expecting that hospital employees should be satisfied to work at less than a living wage. It isn't healthy for the hospital to underpay those who serve it. Our present method puts a premium on employment of physical or mental incompetents who are not equipped to compete with those who can qualify for a higher standard of wages outside of the hospital. Stabilization of financing through funds made available under hospital care insurance plans should have a salutary influence.

If the foregoing is at all accurate, it is not difficult to visualize the fundamental change that can come about in our public relations. Today much of the ill will incurred by hospitals and by the medical profession has its basis not in the quality of service delivered but rather in charges made for that service. We can largely remove this irritation. We can look forward to a much happier relationship between those using hospital and medical service and those rendering such service.

We have then a vision of: (1) ultimate prepayment for hospital care on

behalf of a very considerable portion of our population; (2) more definite classification of those clearly below the line of ability to pay even on the insurance principle; (3) opportunity for much clearer emphasis on those things of real importance scientifically and in management, and (4) continuance of strong voluntary hospital service throughout this country integrated closely with ultimate governmental provision for those whom the voluntary system cannot reach.

Improving Quality of Care

With a considerable portion of the burden of money raising for the care of the indigent removed, the hospital may become a place directed more exclusively to the function of producing and delivering hospital and medical care. Will not any program that strengthens and stabilizes the financial base of the voluntary hospital necessarily open the channel for the raising of standards and improvement of the quality of care rendered? Will it not afford an opportunity for increasing emphasis on the training and support of professional skill which are the cardinal considerations in qualitative medical and hospital progress?

The economic crisis has taken its toll in our hospitals. Private philanthropy has been on a starvation diet since the days of peak prosperity. We have found in this period greater difficulties. On the other hand, we have developed greater skill and acumen in the use of our resources through the very economic pressure under which we labor.

Stabilization of hospital income should give us a readier access to private funds contributed by philanthropists for needed building facilities, for constant provision of modern and improved equipment, for encouragement of research, for greater liberality in expenditures on costly but important experimental work and for stipends for especially talented personnel. The horizon is widened for the hospital as a teaching entity both for professional groups and for the lay public. The voluntary hospital should be strengthened as a central dynamic force in refinements of technic and in medical progress with emphasis on research as well as on therapy.

Automatic Safeguard for Sterilizers

CARL W. WALTER, M.D.

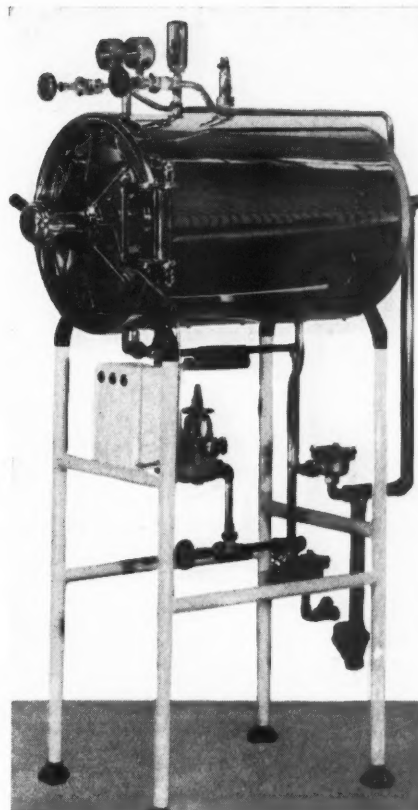
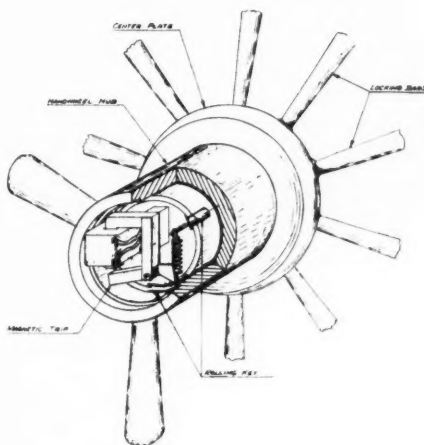
HOSPITAL administrators are directly responsible for the sterilization of surgical supplies. They select the sterilizing equipment, supervise proper installation, select the attendants, dictate the sterilizing schedule, maintain the equipment in safe operating condition and are responsible to the trustees for its successful performance.

Few administrators possess the technical background to evaluate the efficiency of sterilizing procedures; the majority rely upon the pathology department or the operating room supervisor to check on the safety of the surgical supplies without the realization that there has been no reliable routine method of detecting faulty sterilization.

The ultimate safety of any sterilizing technic has been dependent upon the mechanical dexterity and the integrity of those who operate the sterilizers or open the sterile bundles. In most hospitals, therefore, sterile supplies are no more reliable than the ever changing group of inexperienced interns and nurses who use the supplies or who are entrusted with the operation of the sterilizers. Wise administrators agree that safeguards must be utilized to ensure the absolute sterility of surgical supplies.

Numerous devices have been developed to check the sterilization of supplies. Many sterility detectors have intrinsic faults and all of them disregard the human factor, which arises in their proper use and interpretation. None of the controls force the operator to correlate his interpretation of the detector with the actual operation of the sterilizer or the safe disposition of an unsterile load, nor do they prevent unsterile supplies being removed from the poorly functioning or improperly operated sterilizer. To ensure abso-

Cutaway drawing shows the rolling key clutch mechanism that wedges the handwheel so that the sterilizer door cannot be opened until the keys are released by a magnetic trip at the end of the satisfactory sterilizing cycle.



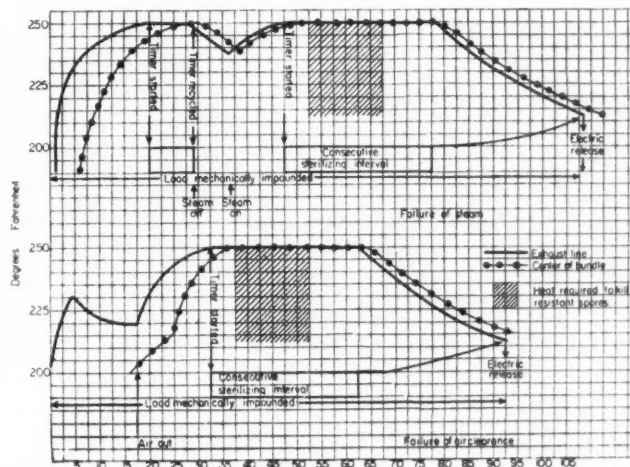
A control on this dressing sterilizer impounds the unsterile load until it has been exposed to saturated steam for a consecutive interval. The control box with its signals, the thermoswitch housing in the exhaust line and the locking mechanism all are visible.

lute sterility, a reliable control must not only reveal failure of the sterilizer itself but must also prevent the human element from disregarding the warnings indicative of a dangerous fault in the process of sterilization.

A control has been designed and used in the Peter Bent Brigham Hos-

pital, Boston, for the past three years which automatically impounds the load until it has been properly sterilized, thus eliminating all opportunity for human error and ensuring the absolute sterility of supplies. This control is fully automatic, indicates the various stages of the sterilizing cycle and enforces a sequence of

Curves illustrating the action of the control under conditions of faulty sterilization. The load is not released until it has been sterilized.



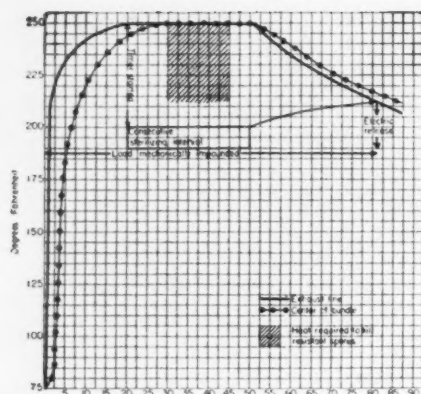


Chart indicating the temperature relationships that must be met during a specified sterilizing cycle before the load will be released.

operation by impounding the load until the specified sterilizing cycle has been completed. The simplicity of design, rugged construction and housing of the control make it both foolproof and tamperproof.

The device is fail-safe because it acts to release the mechanical lock, which impounds the load, only after the satisfactory completion of a predetermined cycle. Thus failure of the control, whether mechanical or electrical, cannot result in the release of unsterile supplies. Any deviation from the established minimum of exposure to steam at sterilizing temperature is indicated immediately by appropriate signals. The control thus furnishes a guide for the proper operation of the sterilizer.

The autoclave door is locked by a rolling key clutch mechanism mounted within the handwheel assembly. This clutch wedges the handwheel so that the locking bars cannot be retracted and simultaneously provides the takeup often necessary for sealing the door against leakage of steam as the chamber pressure builds up. After the satisfactory completion of the sterilizing cycle the rolling keys are released from their wedging position by a magnetic trip.

The sterilizing cycle is checked by a recycling, synchronous electric timer, which is controlled by sensitive thermostats located in the exhaust line of the sterilizer.

The sterilizer is operated according to the manufacturer's usual instructions. When the locking bars are forced into position to secure the

sterilizer door, a switch is actuated, which energizes the control. A red signal indicates that the sterilizer is locked but that the temperature is below that necessary for sterilization. After steam has been admitted to the chamber and the temperature of the steam reaches the sterilizing level, a thermostat, set for 250° F. starts the timer. A combination of red and green signals now indicates that sterilizing conditions prevail. While the temperature of the steam remains above 250° F., the timer meters a consecutive interval until thirty minutes have elapsed, when it trips a switch which changes the signal to green alone, indicating that the load is sterile and that the steam may be shut off and the vent valve of the sterilizer opened.

After the pressure in the chamber has been relieved and the temperature falls to 210° F., a second thermostat closes, releasing the clutch. A white signal indicates that the load is sterile and that the handwheel may be turned to retract the locking bars.

If, for any reason, the temperature of the steam falls below 250° F., the

timer automatically recycles and the entire thirty minute period must be repeated. Thus continuous exposure to saturated steam destructive to bacterial life is assured.

The use of this control provides a reliable check on sterilization in hospitals having dressing sterilizers of adequate size, because overloading of such sterilizers is unlikely.

In hospitals in which the sterilizers are too small, overloading is almost the rule and further precautions must be taken to measure the penetration of steam into the bundles or drums. This can be done by wrapping a steamproof thermostat, set for 250° F., in the center of the largest bundle or most tightly packed drum. The timer then meters the duration of satisfactory sterilizing conditions in the center of the densest portion of the sterilizer's tightly packed load.

This automatic control provides a reliable means of eliminating faulty sterilization owing to failure of the sterilizing equipment and ignorance or negligence on the part of the attendant.

Let's Be Salesmen

ADA BELLE McCLEERY

MOST of us do our day's work without thinking very much about the hospital's business. Yet business can be good or bad for the hospital, just as it can be for a factory, or a bank or a store. Even when we know this to be true, few of us realize that we can do anything about it.

Yet every one of us can be a salesman. Every one of us has some influence with the public. It may be across a desk or counter; it may be a direct service. It may be answering an inquiry or it may be the "smooth service" that results when those out of sight are doing their jobs well.

The sum of these contacts with us is the impression of the hospital that the patient or the visitor takes away with him. Every word that we speak and every move we make help to create the outsider's impression of the hospital.

If we are careless in our work, indifferent or discourteous in our speech or actions, we are making an unpleasant impression and the outsider is likely to seek a friendlier hospital the next time he needs our service. Business will be bad and we will have made it bad.

When we are cordial and helpful and competent, we are being good salesmen, because we are making a pleasant impression on patients and visitors. They associate this pleasant impression with the hospital. Naturally, they will want to come back to us when they need care and to send their friends to us whenever they require hospital care. Business will be good, and we will have made it good.

Each one of us can help the hospital in its efforts to gain patronage and support. Let's be salesmen all the time.

Let's Work Together

DAVID B. SKILLMAN*

AT THE annual meeting of the American Hospital Association held in Dallas, Tex., last September, the trustee section of that association adopted the following resolution:

"It is urged that boards of trustees take steps to encourage their members to acquaint themselves with hospital problems and to participate to the greatest extent possible in local, state and national meetings."

This resolution was adopted after a discussion which indicated that hospital trustees are attempting to conduct their individual institutions without any background of knowledge of broad hospital problems and without any more hospital information than is available at a meeting of trustees of a single institution.

This criticism of hospital trustees is merited not because of indifference of trustees to the welfare and progress of their institutions but rather because they are not sufficiently aware of the changes that have occurred in the hospital world and how these changes have affected and will affect their hospitals. Trustees are not as sensitive to conditions that will affect their hospitals adversely or as quick on the trigger at getting at the root of the trouble as they are to influences that affect their own businesses. The reason for this is obvious. Men see a great way off that which threatens their pocket-books but are slower in acting on matters that do not affect them directly.

There was a time when trustees could conduct their hospitals in a fairly satisfactory manner with the aid of their own business experience and with the advice of their superintendents, without giving a thought to trends in hospital development or to learning how other hospitals were managed. They could be complacent and provincial and use with

Trustees hold the key to the future of voluntary hospitals. This new department will keep them informed on trends and developments affecting their work. Articles and letters will be welcomed

a fair degree of success the small town approach to hospital problems. The depression brought change in all things. Trustees hastened to adjust themselves to whatever change affected their personal interests but thus far have made no marked effort to avert losses and to obtain advantages for hospitals on a broad scale.

The first loss that hospitals sustained through trustee apathy came in connection with governmental relief of the needy. The government undertook to feed, clothe and house its unemployed citizens and to do it so generously that they could continue to run their motor cars. However, when they were taken ill the government did not pay their hospital bills. Not only were the hospitals compelled to furnish these government wards with nursing services and drugs, but during the period of their hospitalization the hospitals also had to supply the food and shelter that the government gave them when they were in good health.

Let us suppose that the government had said to persons on relief: "We will give you enough money for food, suits and overcoats, but when you need shoes, you can just go to a shoe store and get them. The shoe store man will not charge

you for them." If that had happened, every shoe dealer in the country would have rushed to his trade association and such a hue and cry would have been heard in the land that shortly the shoes would have been paid for like everything else.

This imaginary example of discrimination toward shoe dealers is virtually what happened to hospitals, but was anything done about it by hospital trustees? Obviously, the cases are not completely parallel, for voluntary hospitals are prepared to dispense a certain amount of charitable service, but the charity load which hospitals have had to carry since the depression is far in excess of their ability. Some hospitals have incurred huge debts for operating expenses; some have diminished their resources by the use of endowment funds to pay current expenses, and others have been compelled to lower standards of service and equipment.

All of these dire results might have been averted had the eight thousand or more trustees of the voluntary hospitals in this country risen as one man and demanded that the government, since it had assumed the responsibility for the support of a group of its citizens, support them "in sickness or in health."

Within a few months another great governmental movement will get under way: the proposed appropriation of \$850,000,000 for a federal health program. The progress and advancement of our hospitals demand that trustees take a stand on this proposition. If hospital trustees continue to have no higher and no more aggressive conception of their trusteeship than to attend a board meeting every month or so, they may see this huge sum of money spent with the inefficiency and the regard for political consideration that so

*Attorney-at-law and chairman of the board, Easton Hospital, Easton, Pa.

often attend the disbursement of public funds.

On the other hand, if the trustees of our voluntary hospitals will at last awake to their broad responsibilities for the health and healing of persons in their communities, they can assist the government in attaining the great objectives of the proposed health program with efficiency and dispatch and at the same time can obtain benefits for our institutions which otherwise could not be realized for decades. There is not space here to discuss the details of the part that our hospitals could play in the government's health program, but the fundamental idea is that the program should be carried out to whatever extent is possible by and through existing institutions.

For months our colleagues in the medical profession have been looking after their interests in this proposed program. The proposals of the A.M.A. have been heard throughout the land through the stentorian voice of Dr. Morris Fishbein. The hospitals have long had a national association, the American Hospital Association, which at its Dallas meeting last September adopted a set of resolutions offering cooperation in the National Health Program and authorizing a committee to carry on such cooperation. But the constituency of this organization is almost wholly the administrators of our hospitals. These men are responsible for proper administration of the plant which the trustees turn over to them to manage, but cannot speak with the same authority.

To what extent will the trustee participate in this plan of collaboration between the proposed government health program and voluntary hospitals in general? What is he doing to acquaint himself with his potentialities as they affect not only his own institution, but voluntary hospitals generally?

The clamor for socialized medicine grows louder every day. Any form of it will have a tremendous effect on our hospitals. If the hospital trustees of the country take a united stand, their influence will be powerful in advancing or retarding it. Because of its effect on them and their work, the hospitals should present a united front. Indeed, the hos-

pitals can point the way to a satisfactory middle-of-the-road solution.

The point is that boards of trustees can no longer perform their duties to their communities within the confines of their own institutions. They must unite and cause the voice of the American voluntary hospital to be heard throughout the land. The practical way to approach the problem is to have each board appoint one or more of its strongest and

ablest members to become active immediately in the American Hospital Association and in the state associations. See to it that he or they attend the meetings of these associations even if the hospital must pay the traveling expenses. If a trustee of every American hospital were present at these meetings, the benefit to the institutions that have been entrusted to them would be immeasurable.

The Trustee Controls Quality

ROBIN C. BUERKI, M.D.

IN THE expanded place that the hospital of the future will hold in community life, the trustee must play a most important part. No longer is it possible for him to discharge his obligations to the institution he serves by making certain that its finances are sound, even though this responsibility is in itself a heavy one.

During the depression, some hospitals kept their finances in sound position, but at a terrific sacrifice of reduced hospital service. While the service is an intangible, it can never be sacrificed, for when it is, the lives of the patients are actually endangered. A good administrator can keep a hospital at reasonably high standards even if he has an uninterested, lethargic and unprogressive board, but his task is far harder than it should be.

The hospital trustee must accept his share of the responsibility for the quality of medical care given in his hospital not only to his own immediate family but to the community as well. Without the assistance and cooperation of the hospital the doctor can no longer give to the individual or to the community that type of advanced scientific medical care which is their right. Today the hospital must furnish more than excellent beds and board and nursing. It must have a competent staff of house physicians. It must have available for the immediate use of all patients an abundance of special apparatus.

How many hospital trustees actually have visited a modern hospital,

not to visit the sick room of some friend but to visit the hospital as an institution, to learn at first hand about the hundreds of new scientific machines and methods that are made available to all patients in the hospital?

How many have seen the way radium is handled? The larger hospitals have equipment to collect the emanations and these are used on the patient instead of the radium element. This increases the usefulness of the radium and largely removes the hazard of its loss.

How many have seen an electrocardiographic station that breaks down the various components of a heart beat to tenths of a second and allows the doctor to study the variations, both normal and abnormal?

How many have seen the machines for testing basal metabolism that give the doctor an accurate measure of the activity of the thyroid gland, the gland that produces goiter?

How many have seen the milk room, where under sterile precautions milk formulas are individually prepared for each baby in the hospital?

How many have seen a laboratory function in the middle of the night when the ambulance has brought to the hospital a patient dying from loss of blood following an accident?

These are but a few of the interesting devices and services to be found in the institutions that are maintained for the trustee's benefit and his protection as well as for the protection of the public.

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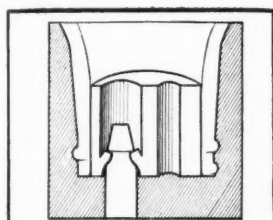
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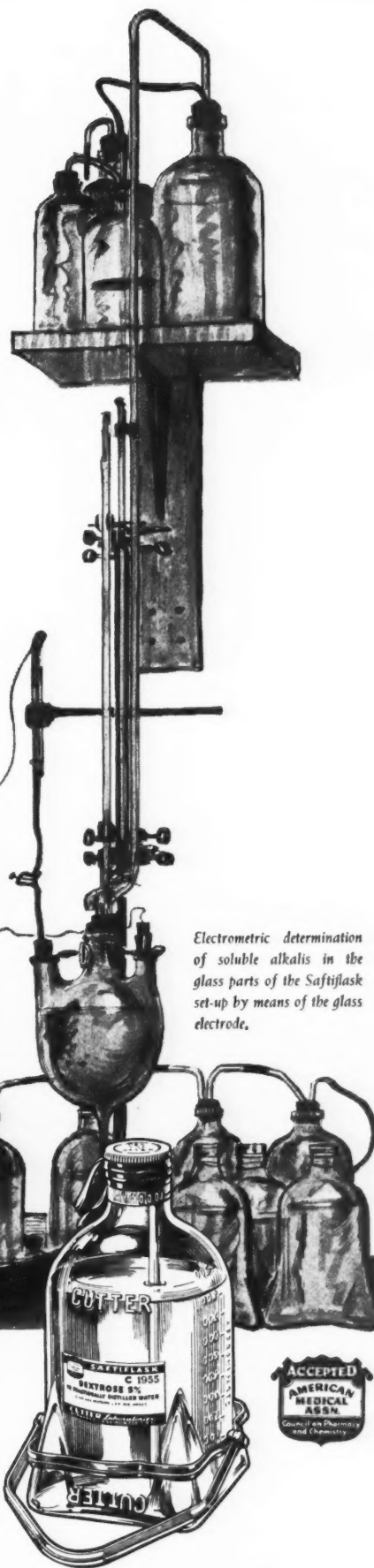
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DEXTROSE SOLUTIONS IN

Saftiflasks

Dry Ice Oxygen Tent

DAVID J. COHN, Ph.D.*

OXYGEN is one of the simplest medicaments available to the physician. It is a natural constituent of the air, of which it forms one-fifth part and its administration merely involves an increase in this proportion, unnoticeable to the person treated. Nevertheless, because of the complicated and cumbersome devices in general use for its application, oxygen therapy often means marked discomfort and even fear to the patient, as well as considerable difficulty and labor to those attending him. Furthermore, high cost of both apparatus and servicing deprives many patients of the benefits of the treatment.

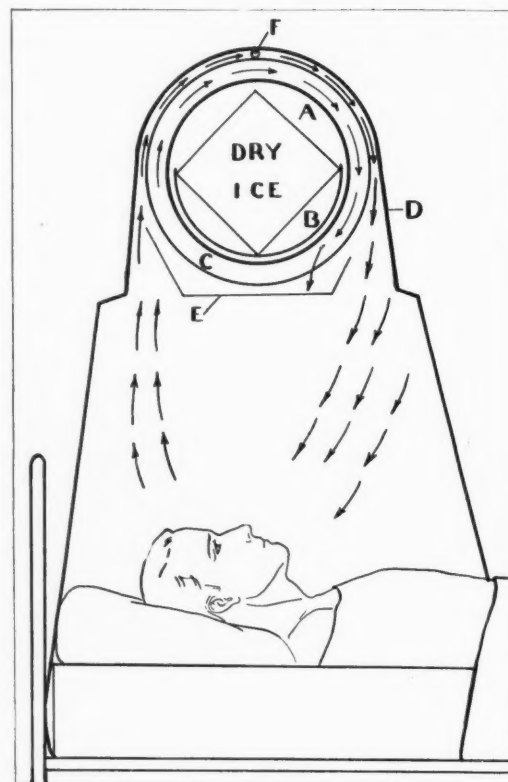
The oxygen tent described in this article is specifically designed to overcome these obstacles and to offer equipment that is compact, simple, inexpensive of construction, easy to service and completely comfortable.

These desired results are obtained by the substitution of solid carbon dioxide, commonly known as dry ice, for the ordinary ice usually used in cooling and dehumidifying the tent atmosphere.

In essence an oxygen tent consists of a more or less air-tight cubicle fitting over the head and shoulders of the patient. Naturally such an enclosed space must be thoroughly air conditioned so as to eliminate the heat and moisture given off by the patient. It is in this process that most of the difficulties in tent design and servicing arise.

In the old form of tent the air is usually passed over crushed ice by means of electrically driven motor blowers. Large ice containers, holding at least 50 pounds of crushed ice, form part of such apparatus; sometimes smaller containers are provided but the results then are not uniform and the tents need almost continuous

Cross sectional diagram of the dry ice oxygen tent showing, A, the dry ice container, provided with, B, a removable, rotating tray holding the dry ice and, C, multiple fins giving a large cooling surface. D is an outer shell, held by a tubular stand (not shown). E is the baffle controlling the direction of the automatic thermal circulation currents, indicated by the arrows on diagram. F marks the oxygen inlet.



attention. From 150 to 200 pounds of ordinary ice are required per day to condition an adult tent. The crushing and handling of this amount of ice, as well as the emptying and disposal of the water as the ice melts, are large problems, especially in a hospital in which a number of units are in use simultaneously.

The dry ice tent efficiently utilizes the superior qualities of solidified carbon dioxide as a refrigerant. A block of this material has three times the cooling power of a block of ordinary ice of equal size. A cylindrical container (designated as A in the diagram), 7½ inches in diameter and 20 inches long, is large enough to hold 25 pounds of the refrigerant, a charge sufficient for twelve or more hours. This container, together with a cylindrical tray (B) to hold the dry ice, multiple fins (C) and an outer shell (D), form the essential parts of the apparatus.

This compact cooling unit is placed

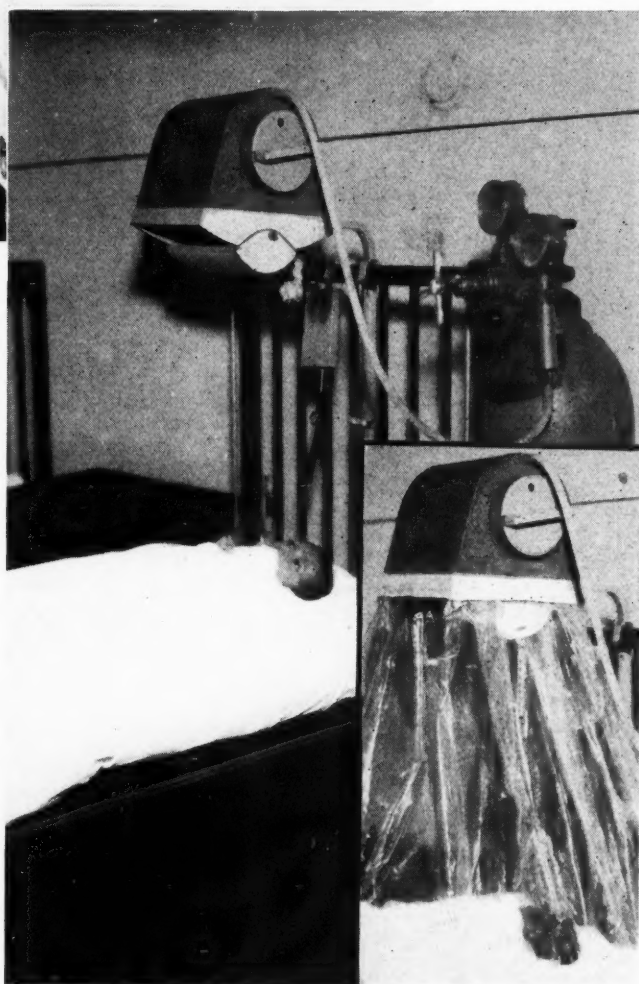
directly over the bed, thus making use of the natural thermal currents, just as is done in well-built refrigerators in which the cooling coils are always placed at the top. The dry ice, evaporating at -109.6° F. supercools the fins and the temperature of the oxygen-air mixture coming in contact with them is lowered instantaneously. This cooled and therefore heavier layer of air circulates rapidly downward and is directed to the front of the tent by a baffle (E), while the warm air around the patient is displaced and rises toward the back as is shown by the arrows in the diagram. Thus a pleasant, even and draftless current is provided, without the cost of a mechanical blower and without the fan noises so often disturbing to the patient and to others.

Excess moisture from the patient's breath condenses on the fins and an ideal degree of humidity is automatically maintained within the tent. The temperature may also be regu-

*Director of the department of biochemistry, Michael Reese Hospital, Chicago.



Note that the nurse has free access to the patient from all sides. The unit is supported by legs under the bed. The rectangular box (left) covers the device for raising and lowering the unit.



The infants' unit is smaller in size and can be hung on the crib. Note that the canopy can be tucked around the bed so that almost no oxygen escapes. There is an opening in the cover of the dry ice container to allow the escape of CO_2 gas as the dry ice evaporates.

lated to any desired point. It is controlled simply by rotating the tray in which the dry ice is placed in such manner that more or less of the refrigerant is in direct contact with the wall of the containing cylinder.

Dry ice is readily obtainable at low

cost because of its widespread commercial use as a refrigerant for the shipping and storing of perishables, for ice cream manufacture and as a source for tanked carbon dioxide gas. It is furnished in neat, easily handled blocks, which fit nicely into the tray.

Dry ice evaporates directly to the gaseous form, leaving no residue to be disposed of. Furthermore, while the melting of ordinary ice is accompanied by dripping and splashing noises, the evaporation of dry ice is silent.

The dry ice container is so constructed that the carbon dioxide gas evolved passes into the outer room air and cannot possibly enter the canopy. The carbon dioxide given off by the patient is partly washed out by the incoming oxygen and partly diffused through the rubber canopy so that no absorbing agent is required. Innumerable tests have shown that the carbon dioxide content of the tent atmosphere never exceeds a small fraction of 1 per cent.

The stand holding the unit is tubular and has an underbed foot, so that it takes up practically no space at the bedside, leaving the patient accessible from all sides. Stand and unit together weigh about 30 pounds and may be demounted and packed into a small carrying case. An even smaller unit following the same general design is in use for infants and children. It weighs about 20 pounds and consumes less than 20 pounds of dry ice per day.

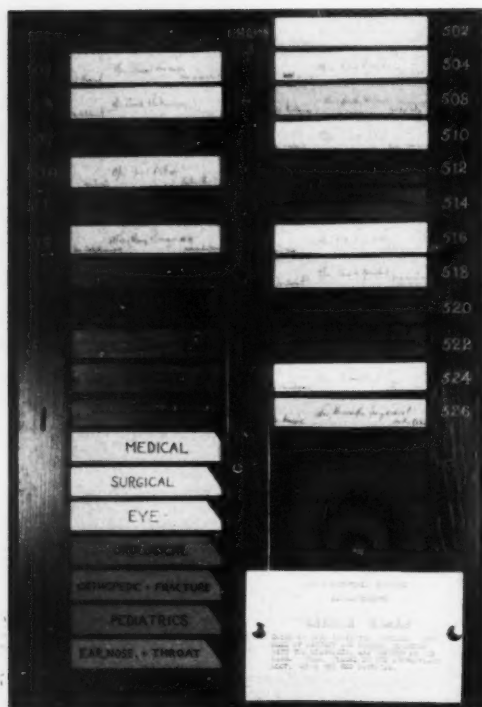
Any rubberized material may be used for the canopy, but pliofilm is to be recommended because of its lightness and transparency. This material is low in cost, so that a new canopy can be used for each patient, a procedure greatly to be desired from a sanitary standpoint.

In this connection the dry ice tent has another advantage in that all parts of the cooling unit are easily accessible for cleaning. Construction is completely of metal and rubber and the whole outfit may be sterilized by autoclaving, a safeguard impossible in bulkier and more complicated outfits.

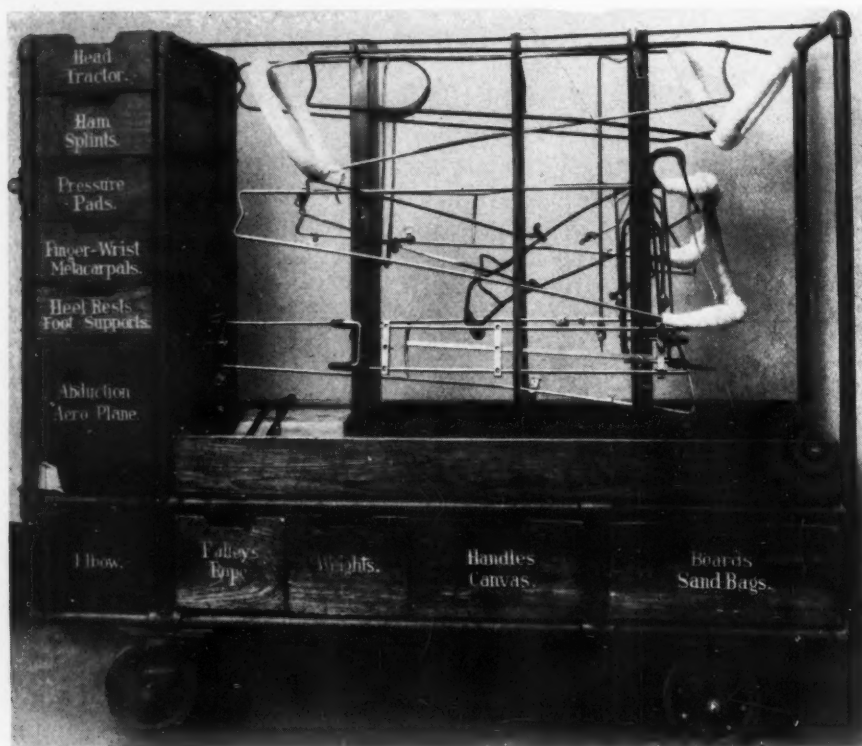
Six tents of this design, some for adults and some for children, have been in use at the Michael Reese Hospital, Chicago, for more than a year and have given uniformly satisfactory service. Patients in them are comfortable and at ease. Little effort is required to set up the tents and to keep them serviced, while their noiseless operation is a boon in the sickroom. Furthermore, the ease with which the patient can be observed and attended is of great value to physician and to nurse.

New England's Gadget Round Table

SIDNEY M. BERGMAN



An ingenious census board that uses colored cards to indicate the type of service. Names of the patient and of the doctor, together with the diagnosis, are written on the cards. Placed in the appropriate slot, each card shows the bed occupied. Entered by the Springfield Hospital.



A fracture truck entered by Peter Bent Brigham Hospital. The two upright posts are divided so that one side holds the apparatus for the lower extremities and the other side holds apparatus for the upper extremities. The drawers in vertical position carry the remaining pieces of apparatus, while the drawers below contain extras. It was agreed to limit the type of fracture appliances that could be cared for on this truck.

RAPID advances made in modern medicine have engendered parallel advances in modern hospital management. This swift development has continually demanded improved methods, which, in turn, have stimulated inventive genius on the part of the hospital administrator and his co-workers.

Several months before the last meeting of the New England Hospital Association, held in Boston, one of a group of Boston administrators thought that it would be a good idea to collect for round table discussion some of the gadgets which must, undoubtedly, exist in New England hospitals for improving hospital service or effecting economies. The suggestion was brought before the officers of the New England Hospital Association and I was asked to solicit and assemble the material.

As the first step, a questionnaire was prepared and mailed to all member hospitals. The amount of interest demonstrated by the response was surprising, for descriptions of 83 gadgets were submitted.

Following the tabulation of the gadgets, the final list was mailed to member hospitals so that they might signify by post card ballot those items which could be considered of most general interest for discussion at a round table at the meeting of the New England Hospital Association.

All entrants were asked to ship to the convention hall drawings, models or the actual gadgets, if size permitted. These were arranged on tables in the assembly hall and labeled approximately. The morning preceding the round table discussion a committee of four members, taking into account the trends of interest indicated by the post card ballot, selected for discussion 13 gadgets from the various entries.

Among the four oxygen tents selected for discussion was a modified Burgess oxygen box entered by the New England Deaconess Hospital, Boston. The apparatus consists essentially of an open-top head enclosure

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or hood, made of sheet rubber, with an opening that may be adjusted to fit about the patient's neck. The hood has windows of cellulose acetate in the front and side walls. When in use it is suspended from an alu-

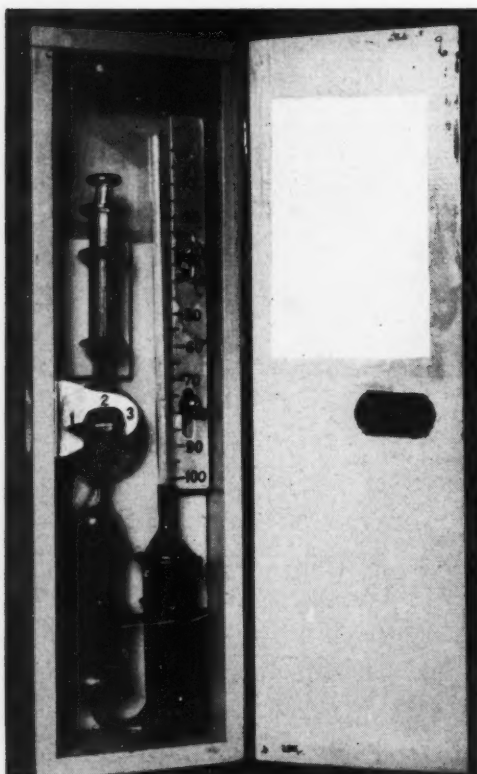
minum frame to form a box with dimensions of approximately 20 inches on all sides.

Oxygen is admitted to the hood through a cooling chamber suspended within. This cooling

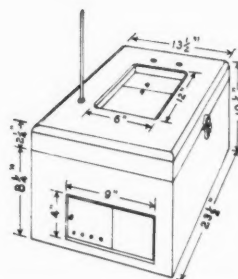
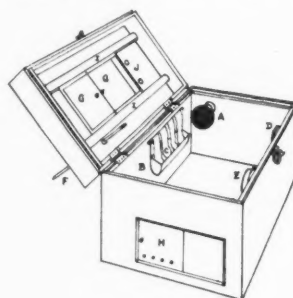
chamber, filled with about 8 pounds of ice, properly conditions the tent atmosphere as to temperature and humidity. Although in ordinary use the oxygen box is open at the top, provision also is made for completing



Infant gavage standard developed at William Backus Hospital aids the nurse in feeding a premature baby.



Apparatus for oxygen analysis devised at Beth Israel Hospital. A three-way valve allows one to obtain a sample of air from the oxygen tent and direct it into the absorption chamber by moving a handle in a clockwise direction.



- A. 25 watt bulb and socket—wire mesh covering.
- B. Water trough (9"x13"x1 1/2")—back extends 2 1/4" above trough.
- C. Gauge strips from trough to wall.
- D. Humidity guide on wall.
- E. Circular thermometer on wall.
- F. Chemical thermometer inserted through cork in top of box.
- G. Sliding window in two sections. Each section 7 1/2" x 6 1/2".
- H. Sliding half door with four 1/4" holes for ventilation.
- I. Grooved runners as guides for window.
- J. Two 3/8" holes in top for circulation. Stock—3/4" white pine. Paint—Ducol enamel, 3 coats.

Improved premature incubator entered by the Massachusetts Department of Health. It can be made up by anyone having mechanical ability.



To minimize the hazard of breakage in the oxygen tent a zipper has been sewed into the rubber skirt of the tent. This permits care of the patient without the transparent canopy being disturbed.

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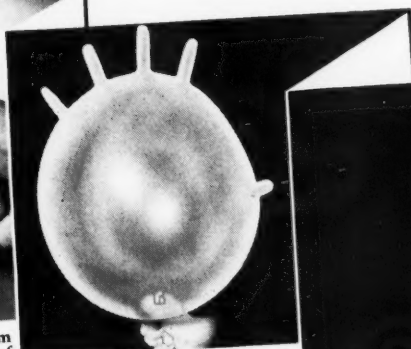
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the head enclosure to obtain 98 per cent of oxygen concentration for special treatments.

Also entered was a device particularly useful in oxygen tent therapy. This instrument will measure and analyze oxygen automatically. Developed at Beth Israel Hospital, Boston, the apparatus is said to be accurate and is simple enough so that it may be used efficiently without any previous instruction or experience. To minimize breakage the analyzer is mounted in a sturdy wooden box and is so arranged that cleaning or replacement of parts is easily possible.

A three-way valve in the analyzer makes it possible to obtain a sample of air from the tent and direct it into the absorption chamber by moving the handle in a clockwise direction. The gas in the absorption chamber displaces an equal volume of fluid into a calibrated tube. As the oxygen is absorbed, the fluid in the calibrated tube automatically falls so that the

percentage of oxygen can be read directly.

Another interesting piece of apparatus was the improvised premature incubator for infants, so designed that it may be placed in the bassinet over the infant. Ventilation is regulated by means of a window of cellulose acetate and a sliding half door in the end of the box nearest the infant's head. A center separation of the window forms an opening sufficiently large for most of the care of the infant without raising the box cover.

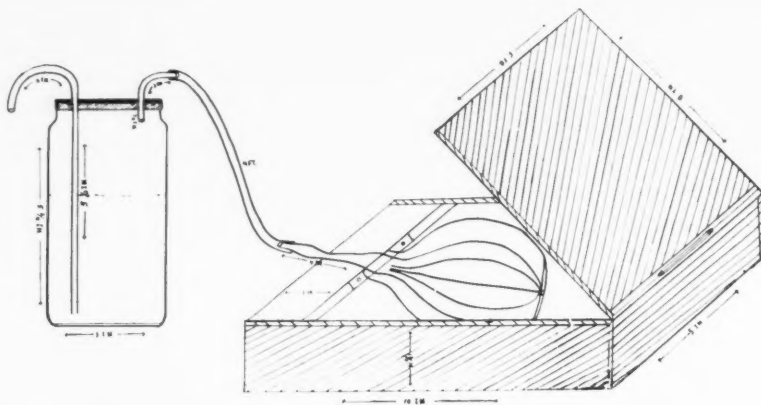
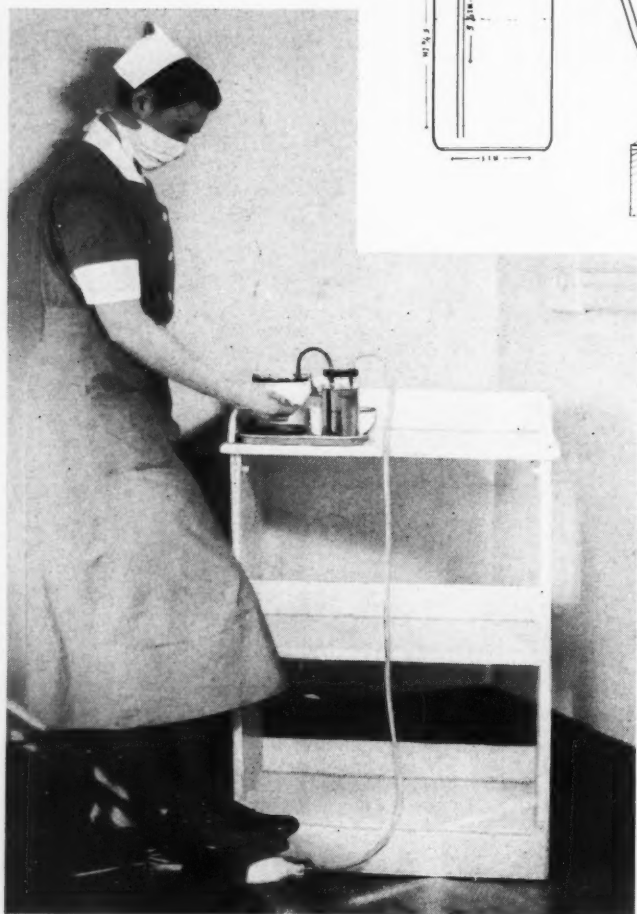
A 25 watt electric bulb will keep the temperature in the incubator at 90° F., in a room temperature of 74° F., with the door and window slightly open. The bulb is covered with a screen to protect it from the bedding. Two thermometers, a chemical and a wall type, are used so that one can provide a check on the other for the stabilization of the temperature. The chemical thermometer is placed in the cover and

the other is placed on the inside wall of the box. A small water trough, which was made from a tin can, is fastened to one wall of the box by means of gauze strips. The trough holds 8 ounces of water and this amount provides sufficient humidity to keep the humidity guide on the inside wall of the box at from 40 to 50 per cent.

An infant gavage standard was entered by the William Backus Hospital, Norwich, Conn. This device, when tried out originally in the maternity department of the Pennsylvania Hospital, was proved to be a satisfactory method of feeding premature babies. It simplifies tube feeding and eliminates the necessity of two nurses when feeding an infant.

Another piece of apparatus for caring for infants was the oil dispenser, also sent by the William Backus Hospital. It utilizes a glass fruit jar that has a cover which can be screwed on with one turn of the

Right: Drawing giving the specifications and mechanics of the foot bulb and pipes attached to the cover.



Oil dispenser entered by the William Backus Hospital. It is made of a glass fruit jar that has brass pipes soldered into the cover. The bulb is of rubber inserted between pieces of wood which are connected by a hinge.

cover. Brass pipes are soldered into the cover, one curved to dispense the oil, the other so arranged that a piece of rubber tubing can be attached. At the other end of the rubber tubing is a heavy rubber bulb, inserted between two pieces of wood that are connected by a hinge for the foot pedal.

Many of the ideas expressed in these and in other gadgets displayed are capable of further development and some are suitable for commercial production.

This initial attempt to display and discuss gadgets met with such enthusiasm and led to so many inquiries from distant hospitals that it appears logical to conclude that the idea may well bear repetition at meetings of hospital associations throughout the country.



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A Housekeeper's View of Asepsis

MARY W. NORTHROP

THE problems of the housekeeping department in regard to the maintenance of asepsis in the hospital consist in establishing a superior standard of cleanliness and in avoiding the spread of contamination.

The first important factor is to have a building that can be kept clean. When a new building is projected, the housekeeper should check its plans and specifications with the cleaning problem in mind. Some of the points she will consider are:

1. All surfaces must be smooth and washable.
2. Corners must be rounded.
3. There must be no cracks. The more nearly the inside of a hospital resembles a china bowl, the easier it is to keep clean.
4. All fixed equipment must be either built into the wall or set far enough from it for ease of cleaning. The distance required depends upon the length of the equipment. A small sterilizer, for example, must be far enough from the wall and from other equipment to admit a man's arm readily, say 6 inches. A mattress sterilizer, which is 8 feet long, must be far enough from the wall to admit the man. If the area to be cleaned is hot (as where there are uncovered steam or hot water pipes) a greater distance must be allowed.

Cleaning Beneath Equipment

5. All fixed equipment that is not built into the floor and all other equipment that is too heavy to be readily moved should be set on legs so that the lowest shelf or rung clears the floor by at least 8 inches. If the legs are hollow, the ends should be sealed.

6. There should be no junk collecting areas, such as closets without a designated purpose.

7. Construction should be such as to minimize the runways for mice and vermin and to exclude rats.

8. All areas that are not sealed should be readily accessible.

9. Either a refrigerator or a room especially built for the purpose is needed for garbage storage. This room should be built in such a way that it can be washed with a hot water hose. Water connections, drains and waterproof electric fixtures and switches should be provided for it. It must be ratproof and verminproof. If the room is not refrigerated, it should be in as cool a location as is possible and have adequate cross-ventilation and screening from flies.

10. A well-constructed incinerator is essential. The space surrounding this incinerator should be constructed like the garbage room, washable and protected from flies. Provision should be made for cleaning garbage cans. Washing with a hose or a spray is not sufficient. There should be facilities for thoroughly scrubbing the cans. A short length of steam hose will be found valuable in finishing the cleaning.

11. Laundry chutes must be washable and a water connection must be provided at the top and a drain at the bottom.

12. Assurance must be given that an ample supply of water at 180°F. will be available in the laundry at all times and that steam pressure will be sufficient to raise the water in the washing machines to 212°F. for boiling contaminated linen.

The housekeeper in an old hospital may find these specifications discouraging but if she will ask the engineer to make the rounds with her, together they may find that many improvements can be made in an old building. The "calling card test" should be applied to cracks, as any crack large enough to admit the edge of a calling card is too large for a hospital. Many cracks, such as those around door frames, can be filled by

Well-trained employees are far more essential in maintaining asepsis in the housekeeping department than are elaborate equipment and a large variety of preparations for cleaning

the maintenance man. Rough surfaces can often be made smooth and corners can sometimes be rounded.

Perhaps pieces of equipment that are difficult to clean behind can be moved. Some inaccessible areas, such as the space under built-in cupboards, can be opened up by making a panel movable or by cutting a door. Given a back yard, proper provision for garbage storage and removal can be made at little cost in institutions that seem too crowded to give proper space to garbage within the building.

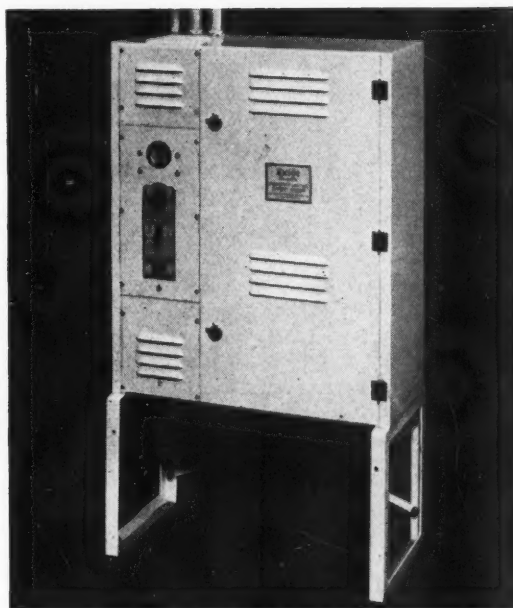
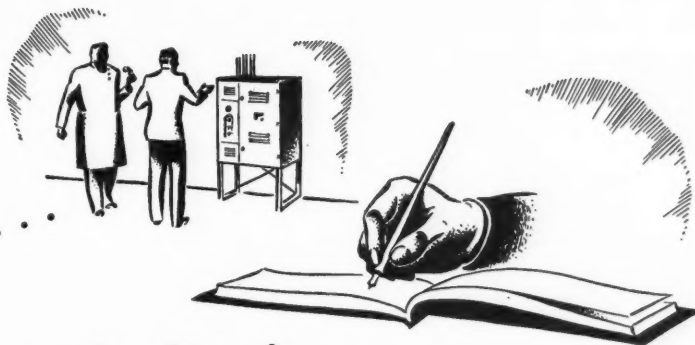
If the facilities of the heating plant are insufficient to supply enough hot water and steam to the laundry, it may be feasible to provide in next year's budget for a boiler to increase the supply, or perhaps it will be helpful to reschedule the work so that the laundry does not call for steam at the same hours that the boilers carry a heavy load for the kitchen and surgery.

The next problem is the training of personnel. The average hospital worker is afraid of infection without having any understanding of the means by which it can be prevented and so assumes an attitude of bravado to cover that fear. He has no conception of the reasons for the rules that are made relative to the handling of contaminated material, with the result that even if he remembers to follow the letter of the law he often violates its spirit. Told that garbage is contaminated, he will

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avoid handling it with his hands and will wear canvas gloves for protection, which he afterward puts in his pocket.

Would it be feasible for the hospital bacteriologist or the nursing instructor or the supervisor of the communicable disease unit to give a course of half a dozen lectures and demonstrations to the nonprofessional personnel? The terminology could be simplified so as to be understood easily and members of the class could be asked to repeat the demonstrations. The type of person who is employed as a hospital cleaner learns by doing better than by the lecture method.

It is sometimes helpful to give the employes two or three slogans that are easy to remember. For example:

"Nothing belongs on the floor except the feet." The floor is always a contaminated area. Articles dropped on the floor should be considered contaminated.

"Remember that the germ carriers are the three F's—Food, Fingers and Flies."

It goes without saying that the housekeeper herself must have a knowledge of bacteriology, the principles of hygiene and the technic used in handling communicable disease. If her background has not given this information, she must take pains to obtain it. If courses in local schools or colleges are available to her, she should enroll by all means. If not, she has access to the public library and usually to a good nursing library as well.

Improved and Simplified Methods

Times have changed in hospital housekeeping and procedures have been improved and simplified with better understanding of the problem.

Scrubbing brushes and harsh cleaning methods are not compatible with smooth surfaces. Smooth surfaces give up their soil more readily than coarse or rough surfaces and therefore promote the cause of cleanliness as well as add to the attractiveness of the institution's appearance and reduce its maintenance cost. It is, therefore, a primary responsibility of the housekeeping department to see that these surfaces are not damaged. The housekeeper obviously must be enough of a chemist herself to understand the reactions of cleaning materials.

We no longer believe in magic and we, therefore, do not accept the special claims of manufacturers for their products without critical scrutiny, nor do we load our shelves and confuse our employes with a horde of different cleaning compounds. To have too many preparations in use causes the employe to make mistakes. Besides, it is expensive. There are in general three classes of cleaning materials and we need one representative of each class—an alkali, a detergent and a soap.

The alkalis should be used only under careful supervision, but they are occasionally needed.

Of detergents, or scouring powders, there are many on the market. They usually are composed partly of insoluble material and partly of soap. The insoluble material should not be gritty and the soap should not be strongly alkaline, as grit scratches and alkali damages most surfaces. Both of these qualities are easily estimated before purchasing. Rub a bit of the compound between the thumb and forefinger or between two glass laboratory slides. If it feels coarse between the fingers or scratches the slide, it should be rejected for cleaning fine surfaces. Alkalinity can be tested by the laboratory, but the housekeeper also has an ever available indicator of her own that she need not be afraid to use—the tip of her tongue.

The soap that is to be used must also stand the tip-of-the-tongue test and the housekeeper can try it for her own use as a hand soap. If it dries the oil from her hands, it will also attack the oil in paint. With an alkali, a detergent and a soap, the housekeeper is prepared to keep her hospital clean.

The day of the "hospital smell" is gone because we no longer swish antiseptics and deodorants around to give us a false sense of security. Soap, water and daylight are the best antiseptics and if the hospital and the patients are kept clean and there is sufficient ventilation deodorants are unnecessary. The use of a deodorant is an acknowledgment of failure. Doctors and nurses use soap and water for cleansing their hands and the basin of formaldehyde has disappeared. Housekeepers use soap and water for cleansing the hospital, without benefit of a few drops of smelly antiseptic in the mop water.

We no longer fumigate hospitals since we have discovered that the fumes of formaldehyde or sulphur inconvenience us far more than they do the bacteria. When a patient recovers from a communicable disease and is discharged from the hospital, everything in the room that may have been contaminated is washed, including at least that portion of the walls immediately surrounding the bed, and the room is exposed to daylight—sunlight if possible—before being used. Again, the use of soap and water and the sun has taken the place of more elaborate methods.

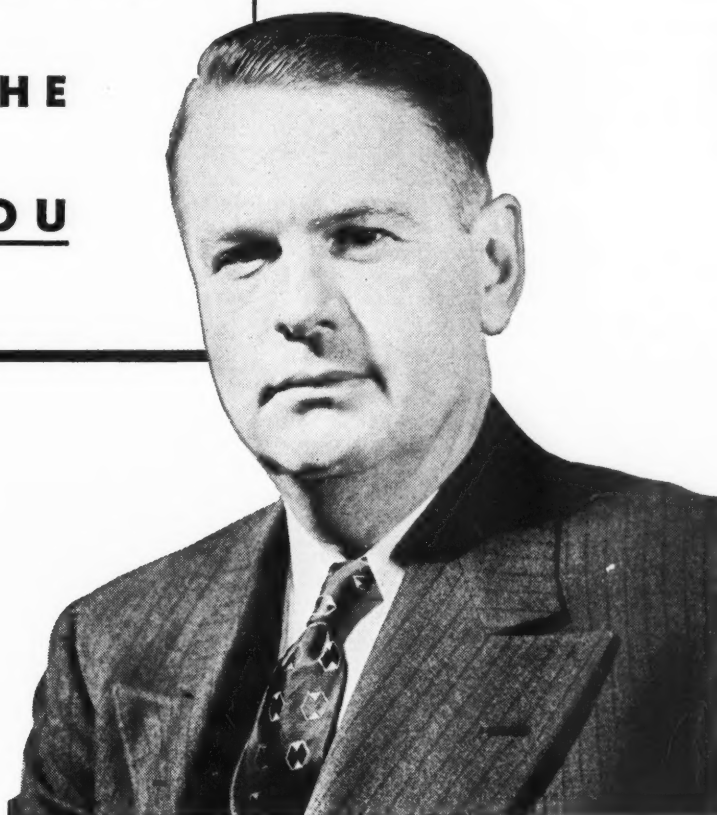
Care of Contaminated Linen

Nurses used to soak contaminated linen in an antiseptic solution before sending it to the laundry. It is no longer considered necessary to have nursing time spent in such work or to have the ward cluttered with tubs of soaking linen.

In the King County Hospital System, Seattle, there are two types of bag that fit the hamper frames. One, of white canvas, is used for ordinary soiled linen. The other, of striped ticking, is used for linen to be isolated. When the striped bag is full, it is removed from the frame and closed with a draw string. It stays closed until it reaches the laundry and the wash man is ready to put the linen into the tubs. Then he opens the bag and empties its contents, without handling, into the wash tub. Here the linen is first subjected to a cold rinse to remove organic material, as is all of our other linen. Then hot water is turned on. This washing is continued for ten minutes after the water starts to boil; in other words, contaminated linens are boiled for ten minutes.

The major problem in the laundry, as elsewhere, would seem to be the education of the personnel. Anyone who has ever visited a large laundry remembers the wash man at his row of tubs, filling one with soiled linen and unloading the clean linen from the next. Both he and any other members of the laundry crew who handle soiled linen must learn to avoid the contamination of their clothing and of the laundry floor and equipment, and they must learn to wash their hands and arms thoroughly between the handling of soiled linen and the handling of

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clean so as to protect the clean linens from contamination.

If they are to wash their hands frequently, the same kind of equipment for that purpose should be provided for them as for other hospital workers. They cannot leave their work to walk the length of the laundry to a wash basin. They should not use the type of faucet that is turned on by hand and thus contaminate the faucet. A sink with knee-controlled faucets and running warm water should be provided in the laundry washroom. Often in hospital laundries the only water available is that piped into the wash wheels.

No problem of the housekeeper is more important to cleanliness and the avoidance of infection than the control of vermin. In handling this problem an ounce of prevention is worth a pound of cure. The old institution thought of rats, mice, cockroaches, bedbugs, flies and mosquitoes as necessary evils to be vigorously combated, in order that they might not run away with the house, but probably never entirely to be eliminated.

The modern point of view is that if these pests do not enter the buildings there will be no problem of exterminating them. Far from being patient under afflictions, hospital officials consider that one such biological specimen is one too many. They check the buildings to discover the avenues of entrance of rats and mice and to eliminate as far as possible their routes of travel within the building. The grounds, and perhaps the neighborhood, are checked for the breeding places of flies and mosquitoes. With the disappearance of stables, flies are less numerous in cities but there still are enough to cause concern. Screening should be carefully watched and repairs should be made immediately.

In spite of the greatest precautions, however, vermin enter the hospital and it becomes the housekeeper's problem to eradicate them. She will use different methods for different pests. The campaign against flies and mosquitoes will be waged by the whole hospital personnel, with newspapers and spray guns, which the housekeeper will have distributed generously enough so that they are conveniently available.

Bedbugs are usually not a major problem if they are reported promptly,

while only one bed is infested. If the bed is properly constructed so that the bugs cannot get inside of the pipe frame, washing will suffice for the bed itself, while the mattress can be either sent to the sterilizer or thoroughly exposed to the sun.

In some communities the city health department maintains a rat catcher who will assist in ridding the premises of rats and will advise in ratproofing operations. If the control of those most persistent pests, the mice and the cockroaches, proves difficult, a competent exterminator employed on a monthly contract will be worth more than his services cost.

The maintenance of hospital asepsis, then, as it affects the housekeeping department, becomes a question

of people rather than of things. Little is needed in the way of equipment but a great deal is needed, qualitatively speaking, in the way of personnel. The department head must have a sound knowledge of her subject based on theory as well as practice and an alert mind so that she will not "strain at a gnat and swallow a camel." She must be supported by an intelligent group of employees whose working conditions and wages are such that labor turnover is reduced to a minimum in order that she may train them adequately. The teaching ability of the housekeeper and her opportunity for effective instruction seem to be the foundation stones on which success in this field must be built.

THE HOUSEKEEPER'S CORNER

- Did you ever see a sponge in a cage? This original idea for keeping track of those large, expensive sponges used for wall cleaning is used with success at the University of Chicago Clinics, where it was not unusual for a half dozen sponges to disappear during spring or fall housecleaning. The cages, which form a neat section near the door to the housekeeper's office, were made by the clinic carpenter. Each cage has a heavy wire door fastened with a padlock. When the sponges are issued the workman is assigned a cage for his sponge and a key. After the day's work the sponges are cleaned and returned to the cages.

"Not a sponge has disappeared since we installed the cages several months ago," says Marie Neher, housekeeper.

- Bath towels that are badly worn may be cut into 12-inch squares to make soft and absorbent wash cloths. The remainder of the towels may be used for dust cloths.

- To save time spent in counting pieces in the linen room at Children's Memorial Hospital, Milwaukee, laundry workers fold diapers and pack them in bundles of 25 after laundering. These bundles are then distributed to the floors. Safety pins are strung together in bunches of 12 and are counted by strings.

- When dark woodwork, such as mahogany doors and trim are to be painted white or ivory, an effective means of preventing the dark color from coming through is suggested by

Marion Wyatt, executive housekeeper at the Sherman Hotel, Chicago. The woodwork is first sanded down to remove the finish and give a surface to which the sealer will adhere. A coat of aluminum paint is then applied. After it has dried thoroughly, two or more coats of white paint or enamel are applied to give a lasting finish.

- A miscellaneous collection of paint brushes and cans of left-over paint is an unsightly decoration in many hospital paint shops and an annoyance when space is at a premium. A resourceful painter in Newport, R. I., according to the *Dutch Boy Painter*, makes use of two old bed springs in storing brushes and paint buckets. The bed springs are nailed flat against the wall, one serving as a brush rack and the other providing a place to hang the paint buckets. Small pot hooks hold the brushes and buckets. Holes are bored in the handles of the paint brushes. The device helps the painter to see at a glance just how many brushes and how many cans of paint are on hand at one time. When the paint and the brushes are returned from the job, the brushes are cleaned thoroughly and hung on a hook, ready for the next job.

- After flimsy rugs and those that have become worn thin have been cleaned at Michael Reese Hospital, Chicago, the rugs are laid face down and a sizing of thin glue is applied to the back. After this coating has dried thoroughly, the face of the rugs are brushed vigorously to raise the nap.



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- 2** It was the first Hospital Supply House to publish its catalog and price list with net prices, stripped of all camouflage, hidden discounts or secret rebates.
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As 1939 dawns, we look back as well as forward. The statement of Will Ross policy, reproduced here, is from one of our early advertisements. But it is interesting today because it recalls conditions existing when we started this business with youthful fervor and idealism. In 25 years, we have had no reason to change either the fervor, the idealism or the policies. Our hat is still in the ring.

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Self-Service for the Staff

LILLIAN F. HACK*

FEEDING the institutional family so that mealtime offers a pleasant and satisfying interlude in the daily routine is a problem that confronts every hospital dietitian. What can be done to create a home-like atmosphere, to serve more appetizing food and still remain within the limits of the food budget?

Fortunate, indeed, is the personnel of hospitals in which the importance of good food service is given its rightful consideration by a foresighted administrator. St. Christopher's Hospital for Children, Philadelphia, recently occupied a new building that includes a nurses' home with a carefully planned cafeteria.

Founded in 1875 as one of the first five hospitals for children in the United States, St. Christopher's Hospital for Children serves an English-speaking mill district. Many of the children who come to its out-patient department and who occupy its 79 beds have parents and grandparents who were patients in the institution in their childhood.

Cafeteria service for the staff was inaugurated with the opening of the new building last February. The first month of operation dispelled most of the staff's misgivings in regard to the desirability of the change from waitress service. The hospital staff is composed of an administrative and a clerical department, resident physicians, graduate nurses, a social service department, a dental hygienist, technicians, a dietitian, a housekeeper, a seamstress and nurses' aids. One dietitian intern from Pennsylvania Hospital affiliates each month for small hospital experience and acts as an assistant in the dietary department. There is no training school at the present time. Employees, with the exception of the cook, do not receive their meals as these workers either bring their lunch or go home for meals. Medical students who attend

*Dietitian, St. Christopher's Hospital for Children, Philadelphia.

clinics and classes may purchase meal tickets for 25 cents each.

The kitchen and cafeteria, located on the ground floor, were planned for attractiveness as well as for utilitarian purposes. Walls in the kitchen are of glazed tile in sand color; window and door trim is a pleasing shade of green. A stainless metal dishwashing unit, sinks and table tops have been installed. The dietitian's office is glassed in at the end of the kitchen and commands a view of the receiving stairway from the street as well as of the storeroom and the refrigerator across the hall. Ceilings are soundproof and an air cooling system has been so planned that air conditioning may be added when finances permit.

The cafeteria is an L-shaped room with ivory walls, green woodwork and green venetian blinds. We have tried to make this dining room different from that usually found in the hospital. In appearance the room is similar to an attractive tearoom. The atmosphere is informal and gives a sense of relaxation. Benches of soft green leather line one wall; chairs and tables are finished in an ivory tint. Tables are of the pull-up type, with glass tops, seating two and four persons, respectively. The capacity of the cafeteria, including a smaller room for officers and doctors, is about 50 persons.

Contrasting Color Scheme

Colorful curtains with notes of red and green supply contrast in the cheerful color scheme. China having a flowered pattern, green glassware and brown fiber trays add to the inviting appearance of the cafeteria. Bowls of flowers are a frequent table decoration. Pots of ivy decorate the wide window sills. Linen napkins are used. Counter girls wear tan uniforms with bands of red and green on the collar and cuffs.

Counter equipment is of stainless metal and includes a steam table, a silver box, a sink, an ice cream storage cabinet, a milk urn, a gas and an electric toaster, running ice water and a glass coffee maker with automatically filled thermostatically controlled water tank.

We have tried to combine self-service with enough table service to eliminate some of the disadvantages of the former. Dining room girls are concentrated behind the counter when the doors open and the line is longest. Trays are carried to the tables by the personnel. Counter girls take turns "circulating" in the dining room, removing trays to convenient stands.

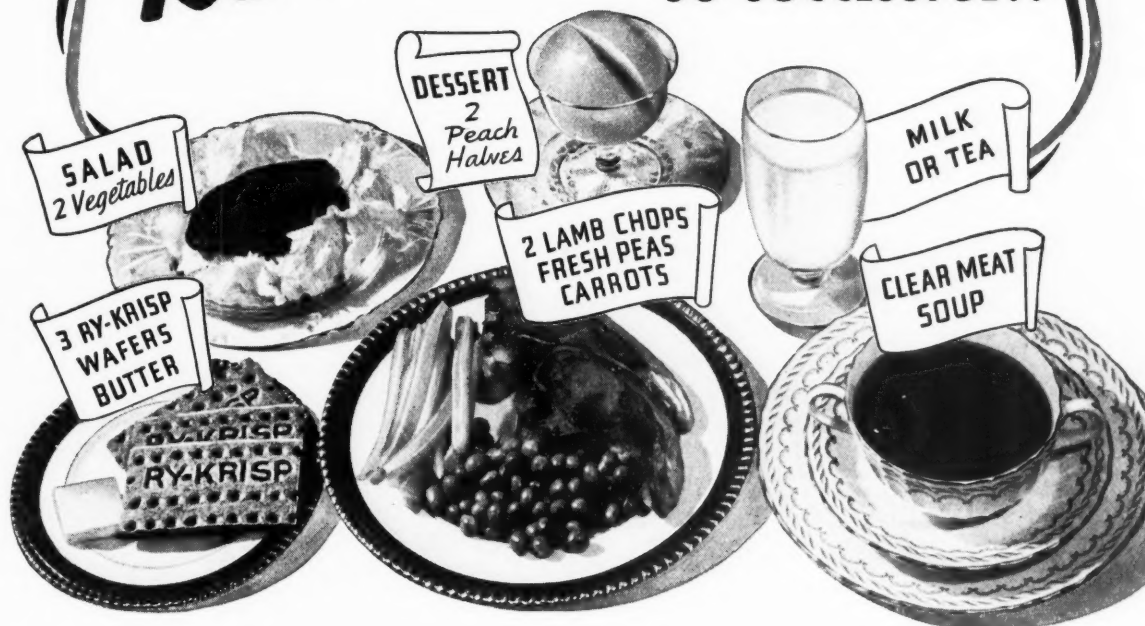
Second Helpings Are Given

Used dishes are removed from the tables as soon as is possible and put through a dish pass into the kitchen. Second servings of food are taken to the tables. This eliminates the necessity for a return trip to the counter after the meal has been started. Coffee is offered at intervals from glass bowls directly from the coffee maker; hot water also is passed for use with individual tea balls. Milk is served at all meals. Both counter and dining room are closely supervised by the dietitian and dietitian intern.

Having a small institution and a fairly constant census enables us to plan and buy closely. A daily meal count is taken by counting the number of trays used. The record is accessible to counter girls so that they may refer to the number of persons served on the corresponding day of preceding weeks. This is an aid in setting up the counter. A number of our staff have the noonday meal only at the hospital, so that the breakfast and the supper census is less than that at dinner.

Low cost food planning is necessary, as well as consideration of labor and time involved in food prepara-

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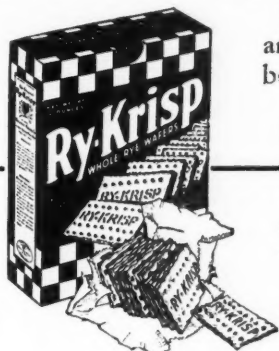
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tion. Good quality food is purchased, as the administration thoroughly agrees with the dietitian that it is poor economy to buy inferior food and have it returned for the garbage can. Staples are purchased weekly and perishables, two or three times each week as needed. Good refrigeration and adequate storage space are of material help in meal planning.

Two record books are kept; one in which all daily invoices are entered, the other containing a perpetual inventory of the storeroom showing purchases and daily withdrawals of supplies. The latter figures are taken from requisition sheets containing a list of items issued for each day. While this method of cost accounting may seem detailed and time consuming it is well worth the effort and the time entailed in keeping records up to date.

Costs at a Glance

At a glance we may make a comparison of total or unit cost of any food for any given period, we may check prices of one firm against those of another, and we may obtain an average daily expenditure for all food. Notations may be made on quantities bought for future reference. No formal system in record keeping has been followed but we have tried to work out a plan that meets our needs and that supplies us with the information that we want.

The menu that is offered in the cafeteria is essentially the same that was used with waitress service. The same food is served to doctors and nurses alike. Much time and thought are given to the planning of meals. Sometimes we wonder whether the members of the hospital family realize just how much time is spent by the dietitian on this one phase of her job. Variety in desserts, salads, garnishes and methods of preparation is constantly sought. Relishes are served freely because they help to dress up the low cost meal.

One of the comments that is always pleasing to the dietitian is: "We never know what we are going to have to eat when we come in." No set routine is followed. Menus in their entirety are almost never repeated. Frequently notes are made on menus as they are filed, such as "good," "do not repeat," "too much preparation" and the like.

Several new recipes are tried each week; satisfactory ones are kept and others discarded or changed to suit our purposes. A recipe exchange is carried on with members of the personnel and augments the dietitian's collection. Nurses are asked to give suggestions about food to one of their group so that these may be discussed with the dietitian. Practical suggestions always are appreciated and are used whenever possible. This collaboration adds to the home-like feeling that we want in our cafeteria as it gives the staff members a part in the food service. Many excellent recipes are brought in and exchanged for those dishes that we serve that are especially popular.

All edible waste food is weighed after each meal by the dishwasher and the amount entered opposite the number of meals on the census sheet. Food left on plates is noted also in clearing tables. Per capita waste averages from 1.5 ounces to 2.1 ounces per person per day for the three meals. If waste is higher than the maximum figure the size of servings is reduced and an examination of the amount and kind of food returned on plates is made. Dishes unpopular with the majority appear on the menu only occasionally.

Counter girls are taught to gauge portions and to inquire whether small or large ones are desired. Waste is less in proportion at the midday meal than at either breakfast or supper. This increase at the morning and evening meal may be because of toast crusts, salad greens and the like. The quantity of food left on plates may sometimes be reduced by changing the location of certain items on the counter. We found that by placing bread last rather than at the beginning of the counter less bread was taken and fewer slices were returned.

One of the complaints often heard in the small hospital in which the same employes must prepare and serve all three meals concerns the inadequate and unsatisfying supper. We have overcome this difficulty somewhat by the careful use of leftovers from the dinner meal and by planning colorful salads, generously served. Salads skillfully mixed and garnished can be arranged in a large wooden bowl with fork and spoon.

A cheese tray offers many possibilities for variety, as does the always

popular relish plate. Fruit bowls are tempting and appetizing on warm nights. We serve cold plates almost altogether during the summer months, and dessert is usually fresh fruit, ice cream or ices. Several kinds of sandwich fillings in small containers, with assorted breads and crackers, save labor during the vacation season as well as help cut waste.

Nurses and others who report for duty at 9 o'clock or those who have long days are given the privilege of having late breakfast. The cafeteria is open from 6:30 to 9:00 a.m. although only about 30 persons are served. While this schedule shortens the time for cleaning the dining room this service is appreciated.

Cafeteria Is Popular

Our cafeteria has been in operation only a few months, yet we feel justified in saying that it is proving successful. Even those of the personnel who were most skeptical of the advantages of self-service agree that the added attention we endeavor to give them obviates many of the reasons for the dislike of cafeteria service in the hospital. While the menu is the same, the privilege of choice, added to the opportunity of asking for the amount of food desired, seems to keep food complaints at a minimum.

Many interesting studies may be made in changing the type of hospital food service. Significant among those that we have noticed among our group are the increase in the consumption of milk and vegetables and the decrease in that of bread. In the small group it is possible for the dietitian and counter girls to note individual food habits as well as likes and dislikes of members of the staff. We cannot hope to eliminate all food complaints; however, we can study them and in many cases make changes that result in a better understanding between those preparing and serving the food and those served.

The small hospital cafeteria offers a challenge to the dietitian who has ingenuity and imagination, in addition to a sound knowledge of purchasing and food values. She is well repaid for the time and effort that she and her department expend to make meal time pleasurable by the appreciation and satisfaction of those of the hospital family among whom she lives and works.

Read how another famous restaurant owner found "Guaranteed Profits in Birds Eye!"

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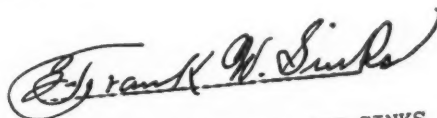
First and most important, they're garden-fresh. We know that our customers enjoy and appreciate good foods, and we have never been able to find in the open market so-called fresh fruits and vegetables as dependable and uniform in quality as Birds Eye Foods. Also we have found over a considerable period of time that Birds Eye Foods guarantee us a satisfactory profit margin.

With Birds Eye Foods we are able to serve as delicious a Strawberry Shortcake in January as in June. We can feature farm-fresh Lima Beans and Asparagus right in the middle of winter. These are only a few of the Birds Eye Fruits and Vegetables that we serve regularly and economically. And we can actually figure in advance each individual-portion cost right down to the fraction of a penny!

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This Month Test Birds Eye Foods for yourself—with Strawberries!

Big and small restaurants everywhere feature delicious Birds Eye Strawberries on their menus. Give *your* customers a treat by serving them now out of season. They come in 2½ pound packages, all ready to serve. And not expensive, either, when you consider how they convert occasional patrons into steady customers. Remember . . . Everybody Likes Strawberries—*especially Birds Eye!* Order some from your local Birds Eye Distributor today. This is only one of 30 different Birds Eye Fruits and Vegetables.



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Contacts for Stimulation

MARY E. SMITH*

MANY and lengthy articles are written about the dietary department, its equipment, the purchase and handling of foods and the training of employes for this work; but of the dietitian as an individual we seldom hear. The very fact that she is accepted as the proverbial hub around which the spokes revolve increases the danger that she will become just that: inanimate, mechanical. In that direction lies destruction of individuality and individual efficiency.

There is much discussion about preparing a dietitian for her work by taking college courses or internships, but when she becomes a finished product and obtains a job she is of no further interest, except insofar as she is able to produce desired results in her individual department. It is a good bet that in nine out of ten cases she ultimately subsides into a rut.

I should be interested in the answers to a questionnaire addressed to the employed hospital dietitian, propounding questions as to how well she is actually keeping up professionally and in a general way with what goes on around her and as to how much interest she is taking in activities outside her ordinary work day.

My guess is that the answers, if they were honest, would reveal that the average dietitian, if she is doing her job at all well, enjoys her work and her hospital contacts, takes a moderately active part in her professional organizations, reads the headlines of the daily newspapers, glances over the articles in one or two professional journals, keeps up with several continued stories in current magazines, sees an occasional movie and "lets the rest of the world go by."

What are you doing to avoid stagnation? Do you have a workable library with reference books on internal medicine, physiological chemistry, bacteriology, physiology, avitaminoses and clinical allergy as well as academic and medical dictionaries and the latest really good works on nutrition and diet therapy? Excel-

*Chief dietitian, Memorial Hospital, Houston, Tex.



Checking lists in the dietitian's office at Memorial Hospital, Houston, Tex. Left to right are Mary E. Smith, Blake Patrick and Patricia Harden.

lent additions to any library are a book of quotations, a book of synonyms, an atlas and a letter writer's manual. What is more to the point, how many of you know what books are in your libraries?

It is not wise to subscribe for more professional periodicals than it is possible to read; rather, select a few good ones that cover the field generally and read them. Set aside one hour a day for professional reading and you will be surprised how soon that will not be enough for the reading you want to do, because as you read current articles, with good reference books at hand, you will want to delve into the "whys and wherefores" of things that are only lightly touched on in the article.

But don't concentrate on the tools of the trade. You are already paying for a newspaper; read it. Select two or more of the splendid periodicals that give you so efficiently the world news and synopses of various discussions in brief, concise form, and read them. Perhaps you have forgotten how stimulating good reading can be.

Then when you sit down with your household journals, have a pair of scissors and a scrap book at hand for cutting and pasting attractive table and tray setups and interesting new food suggestions. Don't put it off until tomorrow, because tomorrow you will surely have discarded the magazine or forgotten where the suggestion was.

Every dietitian is a college grad-

uate and, therefore, eligible to some college alumnae group. I know that the time element enters in to eliminate the possibility of attending frequent gatherings but perhaps there is a book review section one evening a month. Membership in such a group seems to me an excellent means of keeping in touch with those outside the profession and gleaning some more information about what goes on in the world of books at a minimum expenditure of time.

Whether it is the American Association of University Women, a college sorority alumnae chapter, a church or a group of friends that you meet regularly for some game or sport, every dietitian should keep up contacts with women so far removed from her line of work that she is prohibited from talking "shop."

Do you have a hobby? Every busy person should have. It is like choosing your electives in college, part of a well-rounded schedule, no less necessary because it is something you really like. Have you ever let yourself become sufficiently interested in anything not on the required list to let it really get hold of you or are you just a "twiddler"?

I know one dietitian who has a most interesting collection of menu cards. This is an inexpensive hobby that goes hand in hand with the job. Or perhaps you would like to invest a bit in something that goes far afield, something artistic, such as etchings, figurines or old glass.

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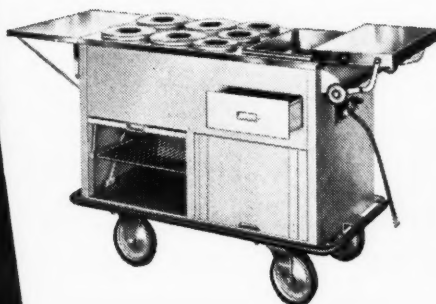
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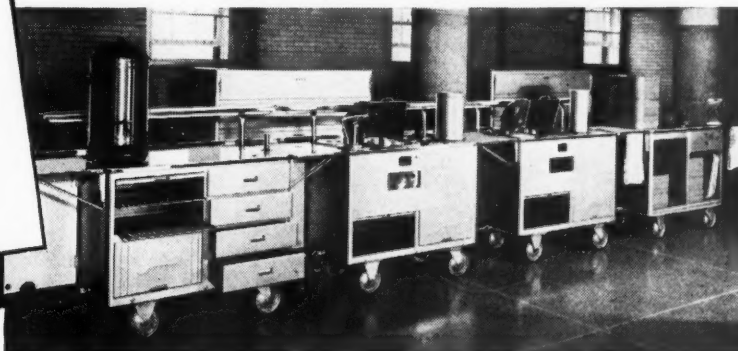
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Partial view of the battery of Ideal Food Conveyors
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Private Room Tray



Consommé, pork chop, mashed potatoes, carrots julienne, peach salad, bread and butter, ice cream with chocolate sauce, coffee.
—Prepared by Evelyn Anderson, formerly chief dietitian, Passavant Hospital, Chicago.

Rolled Shoulder of Lamb



Have a lamb shoulder boned and rolled at the market. Season it with salt and pepper. Place the fat side up on a rack in an open roasting pan. Do not add water and do not cover. Insert a roast meat thermometer so that the bulb reaches the center of the roast. Place in a slow oven (300° F. to 350° F.). When the thermometer registers 175° F. the lamb will be medium done; at 182° F., the lamb will be well done.—Inez Searles Willson, National Livestock and Meat Board, Chicago.

FOOD FOR THOUGHT

- Dealers in "repackaged" foods and others who might care to tamper with a nation's groceries now have a new enemy to face—the spectrograph. By its use, manufacturers who fear that their trade names are being taken in vain can now check simply, quickly and effectively on whether a product actually sold is the real article.

Use of this spectrograph for this purpose was reported to the Food Technology Conference, meeting at the Massachusetts Institute of Technology, by Prof. George R. Harrison of M.I.T.

In addition to safeguarding public health from possible dangerous contamination the device protects the public from adulterated foodstuffs. Food packers can put in their products quantities of a harmless substance so small that only the spectrograph will detect it. Later, a rapid check will enable the packers to learn whether a package bearing a particular brand name is the real article by showing them whether that tiny impurity is present.

- A beautifully illustrated and helpful recipe booklet has been published recently by The Junket Folks, Little Falls, N. Y. It contains some splendid recipes for desserts and ice creams for children and invalids.

- A delicious way of using left-over veal or lamb is to combine it with fruit in a salad. Either of these meats mixed with bananas and pineapple makes a new and different salad.

- Two dietitians who have recently accepted positions in small hospitals and who are doing interesting work in organizing the dietary departments are Helen Wickert, at Graham Hospital, Canton, Ill., and Eleanor McKnight, Milford General Hospital, Milford, Del. Miss Wickert returned to Battle Creek College, Battle Creek, Mich., and received her degree in June, after having had charge of the Y.W.C.A. cafeteria for one year. Since the closing of Battle Creek College, Margaret Ritchie has been appointed professor of home economics at the University of Idaho.

- Beginning a new year by trying to follow in the footsteps of one who has done so excellent a job as has Anna E. Boller in the conduct of "Food Service" is a challenge indeed. However, no effort will be spared to supply the best and most useable food material available during the coming year. If you have any ideas or contributions, don't hesitate to send them along. They will receive a hearty welcome.—DOROTHY DE HART.

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Hospital Superintendents and Pharmacists are invited to send for reprints of published literature and for special price list applying to hospitals and institutions.

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Ertron is within
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Chicago



February Menus for the Small Hospital

Helen M. Druley

Dietitian, Kingston Hospital, Kingston, N. Y.

BREAKFAST

LUNCHEON OR SUPPER

Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Salad or Relish	Dessert
1.	Grapefruit or Orange Juice	Bacon	Chow Mein or Lamb Chop	Rice	Lettuce, French Dressing or Tomato and Endive Salad	Peaches or Pears
2.	Tomato Juice	Scrambled Eggs	Creamed Dried Beef	Baked Potato	Celery Hearts	Baked Apple
3.	Bananas or Pineapple Juice	Poached Egg on Rusk	Clam Chowder or Mushroom Soup	Baked Potato	Molded Pear or Tomato Salad	Royal Ann Cherries or Sliced Peaches
4.	Grapefruit	Bacon	Broiled Tomato and Bacon	Rice	Banana and Nut Salad	Apricots or Nectarines
5.	Oranges	Cherry Preserves	Creamed Salmon and Peas on Rusk	Tomato Soup	Lettuce, Russian Dressing	Applesauce, Cookies
6.	Orange Juice	Scrambled Eggs	Chicken Croquettes	Baked Potato	Tomato Salad	Figs
7.	Apple Sauce or Grapefruit Juice	Bacon	Brunswick Stew or Curried Vegetables	Brown Rice	Prune and Orange or Apricot and Banana Salad	Raspberries or Ice Cream
8.	Dried Apricots or Grapejuice	Poached Egg on Rusk	Escalloped Salmon and Potatoes or Lamb Chop	Green Beans	Stuffed Celery or Endive Salad	Plums or Pineapple
9.	Grapefruit or Tomato Juice	Bacon	Italian Spaghetti or Broiled Ham and Asparagus	Cream of Corn Soup	Lettuce, French Dressing or Combination Vegetable Salad	Royal Ann Cherries or Peaches
10.	Tangerines or Grapefruit	Soft Boiled Eggs	Creamed Sweetbreads on Toast or Mushroom Omelet	Buttered Peas	Grapefruit or Cherry-Nut Salad	Baked Apple or Apricots
11.	Pineapple Juice	Bacon	Chicken Salad Sandwich	Potato Soup	Pineapple and Cheese Salad	Pears
12.	Grapefruit	Orange Marmalade	Chopped Beef on Toast	Baked Potato	Asparagus	Apricots
13.	Prunes or Grapefruit Juice	Poached Egg on Rusk	Scrambled Eggs or Veal Chop	Creamed Cauliflower	Tomato Aspic or Endive, French Dressing	Apple Sauce or Fruit Cup
14.	Tangerines or Grapejuice	Canadian Bacon	Mixed Vegetable Pie	Cream of Mushroom Soup	Date and Pineapple Salad	Peaches or Black Bin Cherries
15.	Grapefruit or Orangejuice	Soft Cooked Eggs	Oyster Stew or Cottage Cheese	Baked Potato	Orange and Banana Salad	Fresh Rhubarb or Ice Cream
16.	Orange and Grapefruit Sections	Bacon	Lamb Stew or Broiled Liver and Bacon	Hot Biscuits and Jam	Waldorf or Sugar Plum Salad	Whole Peeled Apricots or Baked Custard
17.	Bananas	Scrambled Eggs	Macaroni and Cheese	Cream of Tomato Soup	Combination Vegetable Salad	Pineapple or Nectarines
18.	Pineapple Juice or Orange Juice	Bacon	Spanish Omelet or Veal Cutlet	Baked Potato	Stuffed Pear or Orange and Grapefruit Salad	Plums or Peaches
19.	Oranges	Black Currant Jam	Creamed Ham and Mushrooms on Toast	Potato Soup	Goldenglow Salad	Royal Ann Cherries
20.	Grapefruit or Grape Juice	Soft Cooked Eggs	Creamed Chicken on Toast or Broiled Sweetbreads and Bacon	Rice	Beet, Potato, Celery, Mustard Dressing	Raspberries or Nectarines
21.	Dried Apricots or Orange Juice	Bacon	Cheese Fondue or Broiled Meat Patty	Buttered Cauliflower	Lettuce, French Dressing	Royal Ann Cherries
22.	Tangerines or Grapefruit	Poached Egg on Rusk	Spanish Rice or Salmon Loaf	Buttered Peas	Stuffed Celery, Carrot Strips or Endive, French Dressing	Peaches or Ice Cream
23.	Pineapple Juice or Prunes	Bacon	Eggs à la Goldenrod or Lamb Chop	Baked Potato	Pineapple and Marshmallow or Orange and Grapefruit Salad	Cup Cakes or Caramel Pudding
24.	Orange Juice or Grapefruit Juice	Scrambled Eggs	Escalloped Oysters or Rice Omelet	Buttered Asparagus	Lettuce, Russian Dressing or Molded Cranberry Salad	Apricots or Black Bing Cherries
25.	Applesauce	Bacon	Creamed Dried Beef on Toast	Baked Stuffed Potato	Fruit Salad	Baked Apple
26.	Grapefruit	Strawberry Preserves	Corn Pudding, Bacon	Cream of Pea Soup	Stuffed Prune Salad	Pears and Cookies
27.	Oranges or Bananas	Soft Cooked Eggs	Escalloped Turkey and Vegetables	Potato Soup	Grapefruit Salad	Baked Custard
28.	Oranges	Canadian Bacon	Spinach Timbale, Cheese Sauce	Potato Soup	Deviled Egg Salad	Pineapple

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

V. Factors Affecting the Vitamin C Contents of Foods

● Recent development of the chemical method for estimation of ascorbic acid (1) has permitted more thorough study of factors determining the vitamin C contents of foods. Circumspectly used, the 2, 6 dichlorophenol-indophenol or "indicator" titration method for vitamin C determination has proven an invaluable tool in this phase of research.

It is now apparent that the vitamin C content of food at the time of consumption is conditioned, first, by the initial ascorbic acid content of the food at the time of harvesting, and second, by the treatment to which the food is subjected between the time of harvesting and the time of consumption.

The initial vitamin C level in raw foods has been found to depend on factors such as variety, maturity and growing conditions (2). Under usual conditions of food crop production, such factors are only partially subject to human control. However, the factors influencing vitamin C in foods from harvesting until consumption are capable of closer regulation by man.

For example, it is known that long storage at improper temperatures adversely affects the initial ascorbic acid contents of foods. Even at refrigeration temperatures raw foods may lose substantial amounts of vitamin C during storage. Rough handling—which causes rupture of vegetable tissue—is also conducive to vitamin C loss especially when followed by improper storage. Certain metals will catalyze vitamin C destruction and even commonly used home-

cooking methods are attended by losses of this essential dietary factor (2).

Briefly, preservation of vitamin C in foods between harvesting and consumption is essentially a problem of preventing or reducing oxidation, either enzymatic or atmospheric. In addition, physical or solution losses must be minimized in preparation of the food for the table. It is pertinent to note that modern commercial canning procedures are well adapted to control both these chemical and physical losses of vitamin C (3).

The use of prime raw stock and quick transport to the cannery after harvesting; rapid inactivation of enzymes through heat treatment; and large scale automatic operations with minimal exposure to air, are basic practices common to all modern canning procedures. All serve to check oxidative losses of the initial ascorbic acid present in raw foods. In addition, during canning, the foods are cooked by the heat process while contained in the sealed can. The liquid within the can, therefore, retains vitamin C which has been removed from the food by solution.

Researches have shown that many commercially canned foods are to be listed among the most valuable contributors of vitamin C to the diet of the American people (2, 3, 4). Such findings demonstrate the effectiveness of modern commercial canning procedures in preservation to the highest practical degree of the initial vitamin C contents of foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) 1932. Ztschr. f. Untersuch. d. Lebensmitt. 63, 1.

1933. J. Biol. Chem. 103, 687.

(2) 1938. J. Amer. Med. Assn. 111, 1290.

(3) 1932. Ind. Eng. Chem. 24, 650.

(4) 1938. J. Amer. Med. Assn. 110, 650.

1937. Bull. 19-L Nat'l. Canners Assn., Washington, D. C., 4th Ed.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fourth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

Monthly News Review

Vol. 52

January 1939

No. 1

A.M.A. Indicted by Special Grand Jury for Conspiracy and Restraint of Trade

In a suit that is without precedent in the history of American medicine, a federal grand jury in Washington, D. C., on December 20 returned indictments against the American Medical Association, the District of Columbia Medical Society, the Washington Academy of Surgery and the Harris County (Texas) Medical Society of Houston charging conspiracy and restraint of trade in contravention of the anti-trust laws.

In addition to the medical societies, indictments were returned against 21 physicians who are officers of the American or the District of Columbia medical societies. The national officers included Dr. Morris Fishbein, editor, *Journal of the American Medical Association*; Dr. Olin West, secretary and general manager; Dr. William C. Woodward, director of the bureau of legal medicine and legislation; Dr. William D. Cutter, secretary of the council on medical education and hospitals, and Dr. Rosco G. Leland, director of the bureau of medical economics.

The charges declare that the defendants combined and conspired to prevent Group Health Association, Inc., of Washington, D. C., from arranging for the provision of medical care and hospitalization for its members and their dependents. One of the methods by which this is alleged to have been done is by bringing pressure upon the hospitals to deny staff privileges to any physician who is employed by Group Health Association. Another method charged is the preventing of physicians on the association staff from obtaining consultation with any member of the district medical society.

In discussing the investigation that preceded this indictment, the board of trustees of the A.M.A. reported to the house of delegates at the special session last September that "the statement has been made repeatedly that the A.M.A. welcomes investigation by any authorized agency of the nature of its organization, of its methods of work, of the conduct of its affairs and of its activities, firmly reliant on the belief that every action taken by the association has been in accordance with its

constitutional organization in the interest of the public welfare, and for advancing the standards and quality of medical service for the American people; and that at no time has it violated the established law of the federal, state or municipal governments of this country. Moreover, by the very nature of its organization, it has observed constantly the democratic principles on which the government of the United States is founded and maintained."

Ask Clinic Service for Persons on Relief Rolls

A strong demand that relief clients be permitted to attend out-patient departments as well as physicians' private offices and that such clinic service shall participate in the state medical care program for the indigent was voiced recently by the Hospital Association of Pennsylvania. The association stated that it was more concerned with establishing the principle that clinics should participate in the program than it was in setting a high fee for the service and suggested that a minimum fee of \$0.50 be adopted.

This demand is made, it was stated, so that the relief program shall not have the effect of subsidizing one particular kind of medical care and to preserve for clinic patients the right to choose clinics if they prefer. The association and the state medical society are considering the problem jointly.

Hospital Gets \$575,000 Gift

Public acknowledgment of a \$575,000 gift to Passavant Memorial Hospital, Chicago, was made at special ceremonies at the hospital recently. The donor was Edith L. Patterson of Sterling, Ill., and the gift was in memory of her brother, Floyd Elroy Patterson.

The gift, together with certain funds in the possession of the hospital, was used to liquidate the mortgage indebtedness. It also enabled the hospital to devote the sum of \$12,000 a year to conduct further study in the field of cancer research and also to relieve the suffering of cancer patients.

Speakers Named for Minnesota Institute for Administrators

Ada Belle McCleery, C. Rufus Rorem, E. A. Van Steenwyk, A. F. Branton, E. S. Mariette, Dr. Arthur C. Bachmeyer, Dr. William A. O'Brien, Melville H. Manson and Dr. Malcolm T. MacEachern are among the nationally known hospital authorities who will lecture at the Institute in Hospital Administration to be held at the Continuation Center, the University of Minnesota from January 23 to 28.

This institute, which is an outgrowth of the three day institute held for the last two years by the Minnesota Hospital Association, is sponsored by the university, the association and the American College of Hospital Administrators. In addition to providing suitable quarters, the university faculty will be drawn upon for nine of the lecturers. Field trips to the Twin City hospitals are being arranged and round table discussions each afternoon. Tuition for the course is \$15 and the entire cost including room and meals is approximately \$25 to \$28, depending upon accommodations chosen.

Other institutes planned for the university's Continuation Center are as follows: record librarians, January 30 to February 1; dietitians, February 13 to 15, and medical social workers, February 22 to 24.

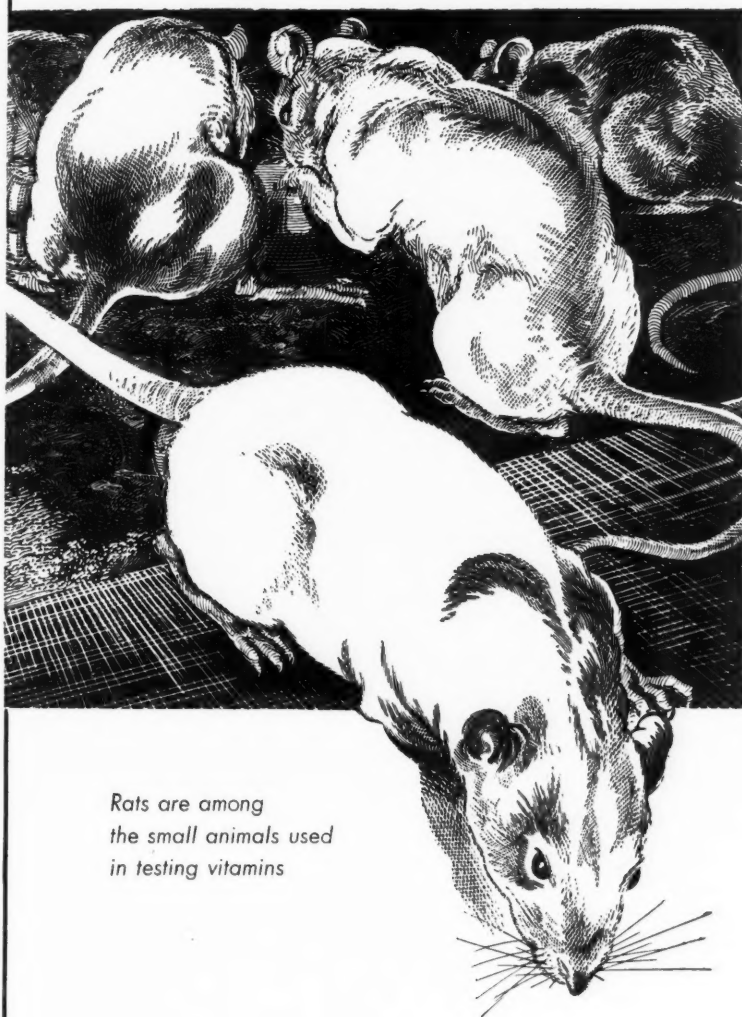
St. Vincent's Modernizes

Completion of a \$700,000 modernization program at St. Vincent's Hospital, Erie, Pa., is set for next July. The extensions consist of an air conditioned 60 bed maternity home, a diagnostic clinic and laboratory, and a power house and laundry, all of which will adjoin and will be connected by means of underground passageways to the main hospital. The capacity of the hospital will be increased to nearly 300 beds.

Syphilis Campaign Has "Day"

National Social Hygiene Day will be observed throughout America on February 1. Some 5000 meetings to highlight community campaigns against syphilis and to call attention to the next steps in combating the disease are scheduled.

Vitamin Therapy has made such rapid progress that it has become an important factor in medical practice. So many vitamin products are offered for sale, so many claims are made for their therapeutic value, that the subject is somewhat confusing. The element of chance is removed when "Lilly" is specified. Lilly Vitamin Preparations are biologically tested according to approved methods. Their strength and uniformity are guaranteed.



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'Betalin Compound'

(Vitamins B₁ and B₂ Complex, Lilly) Pulvules

'Betalin S'

(Synthetic Vitamin B₁, Lilly) Ampoules

'Betalin S'

(Synthetic Vitamin B₁, Lilly) Tablets

Calcium Gluconate

with Vitamin D, Lilly, Tablets

'Cevalin'

(Vitamin C, Lilly) Ampoules

'Cevalin'

(Vitamin C, Lilly) Tablets

Dicalcium Phosphate

with Vitamin D, Tablets

'Hepicoleum'

(Vitamins A and D, Lilly) Globules

'Hepicoleum'

(Vitamins A and D, Lilly) Liquid

'Hepicoleum Compound'

(Vitamins A, B₁, B₂, C, and D, Lilly) Globules

'Melvaron'

(Malt Extract, Vitamins, and Iron, Lilly)

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Hospitals Obtain More Than \$813,340 in Five Successful Fund-Raising Campaigns

Five successful hospital fund-raising campaigns have been reported recently. The Homeopathic Hospital of Montreal, Quebec, sought \$250,000 to liquidate indebtedness, provide a nurses' home and an increase in bed capacity and to extend out-patient facilities.

Although the campaign's opening came simultaneously with the darkest period in the recent "war scare," the effort developed into a marked community success. It resulted in October in an oversubscription of more than \$54,000. Nearly a thousand volunteers helped in the campaign.

Facing serious debt problems, the Providence Hospital and the Good Samaritan Hospital of Sandusky, Ohio, although the former is a Catholic and the latter a nonsectarian institution, made common cause of their needs and formed the Sandusky Hospitals Council, Inc., to raise a fund of \$100,000. They agreed to divide the fund equally. Strong trustee leadership created widespread community support from a group of new-found friends re-

sulting in a \$6000 oversubscription in a campaign which closed four days ahead of schedule.

The Newton Hospital of Newton, Mass., had postponed the effort to raise funds for a new nurses' home for the last ten years. Finally the need became so acute that the trustees decided last spring to make a public appeal. A fund of \$242,000 was raised and construction is now under way. These three campaigns were directed by Ward, Wells and Dreshman.

The Northern Liberties Hospital, Philadelphia, of which Nellie A. Gealt, R.N., is administrator, recently celebrated the attainment of subscriptions of \$110,000 in a campaign for a \$75,000 goal.

Public spirited citizens raised a fund of \$51,340 recently to save the Allen Memorial Hospital at Waterloo, Iowa, from foreclosure. The money will meet outstanding debts with the exception of about \$80,000 that is assumed by the Lutheran Good Samaritan Society, which will take over the hospital.

Associated Hospital Service of New York Has Feathers in Cap

A clear-cut stand in support of the Associated Hospital Service of New York was taken by a resolution of the Greater New York Hospital Association passed on November 25. The association pointed out that its member hospitals had helped to start Associated Hospital Service, that they have a voice in its management, and that its terms and conditions are superior to other plans.

For these reasons the member hospitals "are not in a position to render similar participation and support to other plans providing cash indemnities to cover hospital expenses. Moreover, they are not in a position to enter into similar arrangements with other plans that are not approved by the American Hospital Association and do not operate under the provisions of the special enabling act."

The association also established the policy of giving to other hospital care insurance plans that are approved by the American Hospital Association the same terms for service as are given to the New York plan. If the other approved hospital care insurance plans pay at a lower rate than the New York

plan, the hospitals will collect the difference from the patient.

This strong support was a second feather in the cap of the New York plan within the week. Four days earlier, on November 21, the New York plan enrolled its millionth subscriber, having attained this goal in just over three and one-half years.

Frankford Opens Maternity Wing

Appropriate ceremonies attended the dedication of the new maternity wing of the Frankford Hospital, Frankford, Pa., a modern fireproof building with a bed capacity of 50 including private rooms, semiprivate accommodations and two small wards. The south end of the ground floor is devoted to clinics, and the north end contains the pathological laboratory. Elsie L. Miller is superintendent.

Hospital Unit for Negroes

A two story fireproof hospital unit for Negroes has been started as part of a \$191,000 construction program at the Julius Marks Sanatorium. The new unit, which will be for treating tuberculous patients, will cost approximately \$57,300. Forty-five per cent of the cost of the building program will be handled by P.W.A.

X-Ray Test Will Be Given to New York Relief Clients

A mass effort to curb tuberculosis among poverty-stricken families, through x-ray examinations of the 529,000 men, women and children on home relief in New York City was announced recently by Mayor La Guardia. No campaign of equal magnitude has ever been attempted in the past, the mayor told reporters after he watched four persons a minute pass before the x-ray machines at a W.P.A. tuberculosis clinic. The records kept will be "unusually complete," the mayor said, and a full checkup will be made on the families and close friends of persons found to be infected.

Refurnishing Started at Good Samaritan Hospital

Redecoration and refurnishing of entire sections of Good Samaritan Hospital, Phoenix, Ariz., hiring of additional personnel and purchase of new equipment are going forward as the result of one of the best seasons this hospital of 170 beds has ever had. J. O. Sexson, superintendent, in announcing the development program which follows a \$25,000 modernization program of less than a year ago, said he would enlarge the school of nurses. The hospital has one of the few entirely fireproof storage vaults for x-ray films possessed by hospitals in the far west. The vault is placed on top of the hospital and reached by an elevator.

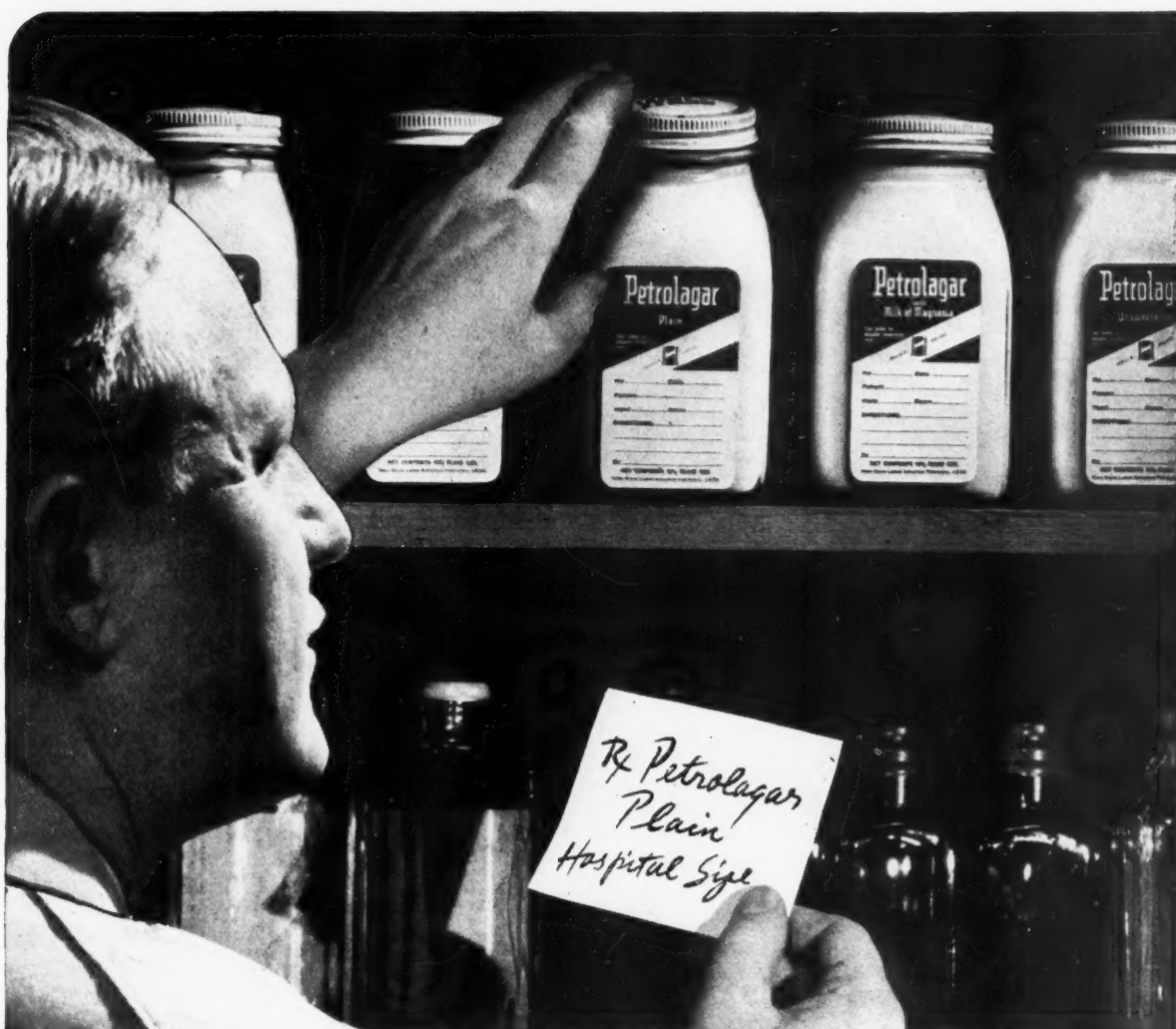
St. Clare's Dedicates New Building

More than a thousand persons attended the dedication ceremonies of the new pavilion in St. Clare's Hospital, New York, at which Mgr. Michael J. Lavelle, vicar general of the archdiocese of New York, officiated. The pavilion is six stories high and is the first of two additions to the hospital. The other building will be built for the out-patient department and a nurses' residence. Robert J. Reiley is the architect.

Carolyn E. Gray Dies

Carolyn E. Gray, long a leader in nursing circles, died December 29 in Miami, Fla. Miss Gray was editor of the nursing department of *The Modern Hospital* from August 1918 to February 1927. As first dean of the school of nursing at Western Reserve University, she sprang into national prominence. She has held various other important educational and administrative positions since that time.

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Cooperation and Unified Management Recommended for 5 Rochester Hospitals

Because the five voluntary hospitals participating in the community chest of Rochester, N. Y., have failed to cooperate, an unnecessarily heavy burden of cost has been placed on both patient and community, it is charged by Dr. Carl E. McCombs in a survey of certain administrative functions of these Rochester hospitals.

The report states that economies might be possible through unified management of certain business functions.

Included in the survey were Rochester General Hospital, St. Mary's Hospital, Highland Hospital of Rochester, Inc., Genesee Hospital and Convalescent Hospital for Children.

Chief findings include:

1. Since the inauguration of the Rochester Hospital Service Corporation insurance plan hospital incomes from paying patients have increased greatly.

2. Hospital expenditures for all purposes have increased a net 16.6 per cent since 1931-32. Expenditures for personal services increased only 10.8 per cent in the same period, while expenditures for services other than personal increased during this time a net of 25.1 per cent although patient days increased only 13.6 per cent.

3. Serious losses have been caused by the hospitals' failure to prevent and collect delinquent accounts. An attempt is now being made to collect these accounts, yet nearly \$200,000 has been written off the books within the last three years.

4. Hospital budgets are based on an accounting method that is not adapted either to good budgeting or to proper accounting.

5. Hospital statistics of patients and their distribution by character and extent of service rendered and of payment therefor are inadequate to permit effective planning of hospital facilities and their use.

6. The average length of stay of all insured medical and surgical patients in the hospitals is less than that of uninsured medical and surgical patients by one and one-half days.

7. Analysis of purchasing and control methods in the handling of supplies, materials and equipment shows disregard of business practice.

8. Ambulance service within the city is handled extravagantly and inefficiently, seven stations and eight ambulances being in use at a cost of approximately \$50,000 annually.

9. Personal service is administered

uneconomically. No method of selecting efficient employees is provided, records of employees are not kept and positions and titles are not clearly defined.

\$50,000 Pledged at Dinner

Dinners still are good devices for fund raising, as the committee for the Brooklyn Hebrew Home and Hospital can attest. At a recent dinner \$50,000 was pledged to provide equipment for the new \$600,000 addition to the institution, which was completed a year ago but which has not been occupied because there was no equipment fund.

Voluntary Health Insurance Plans Appear in New Forms

New forms of voluntary health insurance sponsored by medical societies have been formulated and proposed in many sections of the country in the last two months. Among other medical societies to make such proposals are those of New York State, District of Columbia, Cleveland, Utah, California and Colorado.

Details of the plans vary widely from state to state. The plans sponsored by the New York State Medical Society, according to statements by Dr. Charles Gordon Heyd, will consist of a cash indemnity only. For \$1 per month the subscriber would be entitled to indemnification for physician's bills up to \$150 while \$2 per month would protect him up to \$300 and \$35 a year would give a maximum protection of \$500.

The California plan, which was approved by the state association's house of delegates on December 17, would provide medical service instead of indemnification, according to newspaper reports. Physicians would be paid on a unit basis, with the cash value of a unit depending upon the income of the central fund. The estimated cost is \$2.50 per person per month. No provision is made for family dependents.

Construct Pittsburgh Hospital

Work has been started on the \$2,000,000 Communicable Disease Hospital in Pittsburgh. Architects for the building, which will be 10 stories in height, are Samuel Hannaford and Sons, Cincinnati. Associated with them will be Richard Irvin and Theodore Eichholz, architects of Pittsburgh.

Hospital Exhibitors to Take on New Activities

Three new activities were adopted by the Hospital Exhibitors' Association at a meeting of the executive committee held in Chicago on December 10. The first is to urge exhibitors to promote observance of National Hospital Day through their advertising and personal contacts and to propose to the American Hospital Association that a representative of the exhibitors be appointed to the National Hospital Day committee for this purpose.

An intensive research program for the benefit of the hospital field was approved. The third new activity is an educational program which, through papers, articles and addresses, is designed to provide hospital executives with information on groups or classes of products. This activity was assigned to the association's public relations committee.

Present officers of the Hospital Exhibitors' Association are: F. L. Marvin, president; Elmer Noelting, secretary and treasurer; Edward Johnson and T. J. Rudesill, trustees, and Charles J. Coleman, George J. Hooper, Lawrence Davis and C. H. Wantz, directors.

Plan Exposition Hospital

A fully equipped four room hospital will be established for the welfare of visitors to the 1939 Golden Gate International Exposition on San Francisco Bay. The hospital will be on the first floor of the administration building and will have a men's ward and a women's ward with six beds each and two complete treatment rooms. A modern surgery will be equipped to handle any emergency. Other features will be a model diet kitchen and an ambulance unit.

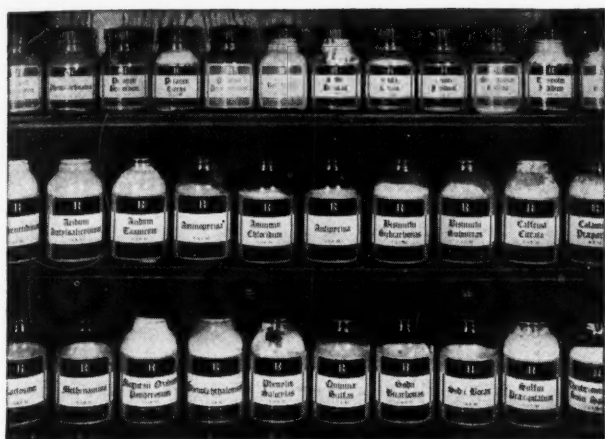
Hospital Gets \$10,000 Donation

A donation of \$10,000 to be used toward building a county hospital for Bay City, Tex., has been promised by V. L. Letulle of Bay City. The proposed hospital will be operated privately without cost to the taxpayers. Under consideration is a plan to move the hospital at Old Gulf, built by the Texas Gulf Sulphur Company, to Bay City, rather than to construct a completely new hospital.

National Hospital Day

Both the San Francisco Golden Gate International Exposition and the New York World's Fair will join in observing May 12 as National Hospital Day.

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Survey Shows Future Need for New 200 Bed Hospital in Detroit

Establishment in Detroit at some future date of a 200 bed hospital under Jewish auspices is the remedy suggested by Dr. J. J. Golub, director of the Hospital for Joint Diseases, New York, for the shortage of hospitals in Detroit. Doctor Golub recently completed a study of the hospital situation in Detroit as a part of the survey conducted by the Jewish Welfare Federation of Detroit, and concluded that the need for additional hospital beds will be increasingly felt from year to year.

"It is generally regarded as desirable for large cities to have five general beds for each thousand population, at 80 per cent occupancy," states Doctor Golub. "Eight of the largest cities in the United States exceed that number. But Detroit, although occupying fourth place in the country on the basis of population, drops to tenth place from the standpoint of its ratio of hospital beds, taking its population at its 1930 census of 1,568,662."

Because Detroit has grown rapidly in recent years and has a predominantly youthful population, more than 75 per cent of which is under 40 years of age, its relative shortage of hospital beds has not yet become noticeable, Doctor Golub asserts.

The study points to the significant factor of increasing bed utilization in Detroit's 42 hospitals that have a capacity of 7,092 beds. The 11 general hospitals, with more than 100 beds each, at the present time admit 77 per cent of the community's patients and are occupied to 85 per cent of capacity.

Laundry Chute Jinx

The laundry chute at Methodist Hospital, Princeton, Ind., is regarded with suspicion by the hospital staff, and with good reason. Repairs to the chute, as a result of a fire in October that caused \$300 worth of damage, had just been completed last month, when a new fire broke out, damaging the chute and destroying part of the hospital's linen supply.

Rebuild County Home

Contracts totaling \$57,858 for rebuilding the County Home Hospital at Carlisle, Pa., which was destroyed by fire last spring, have been awarded and work has started. In addition to insurance funds, an outright grant of \$29,058 has been received from P.W.A. and the remainder is being supplied by the county.

Marine Hospital to Close

Shortly after the first of the year a marine hospital that has served the United States Public Health Service for the last seventy-nine years will close its doors. The hospital is the U. S. Marine Hospital at Chelsea, Mass.

Coming Meetings

1939

- Jan. 18-20—Sectional Meeting, American College of Surgeons (Tennessee, Arkansas, Mississippi, Alabama, Georgia, Florida, Kentucky, Louisiana), Andrew Jackson Hotel, Nashville, Tenn.
- Jan. 23-28—Minnesota Institute for Hospital Administrators, University of Minnesota, Minneapolis.
- Feb. 13-14—Annual Congress of the Council on Medical Education and Hospitals of the American Medical Association, The Palmer House, Chicago.
- Feb. 20—Oregon Association of Hospitals, Olympic Hotel, Seattle.
- Feb. 20-23—Association of Western Hospitals, Seattle.
- March 9-11—New England Hospital Association, Hotel Statler, Boston.
- Mar. 15-17—Sectional Meeting, American College of Surgeons (Maryland, Virginia, District of Columbia, New Jersey, Delaware, Eastern Pennsylvania, North Carolina, South Carolina), Lord Baltimore Hotel, Baltimore.
- Mar. 22-24—Sectional Meeting, American College of Surgeons (Indiana, Illinois, Michigan, Ohio, Iowa, Wisconsin), Indiana Claypool Hotel, Indianapolis.
- Mar. 29-31—Sectional Meeting, American College of Surgeons (Manitoba, Alberta, Saskatchewan, Northern Ontario, Minnesota, North Dakota, South Dakota), Fort Garry Hotel, Winnipeg, Man.
- April 11-13—Ohio Hospital Association, Deshler Hotel, Columbus.
- April 13-15—Southeastern Hospital Conference (Florida, Georgia, Alabama, Mississippi, Louisiana), Roosevelt Hotel, Jacksonville, Fla.
- April 20-22—Carolinas-Virginia Hospital Conference, Roanoke Hotel, Roanoke, Va.
- April 20-21—Mid-West Hospital Association, Hotel Eastman, Hot Springs, Ark.
- April 21-22—Texas Hospital Association, Fort Worth, Tex.
- April 24—National League of Nursing Education, New Orleans.
- April 24—Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church, Kansas City, Mo.
- April 24-26—Iowa Hospital Association, Cedar Rapids.
- April 26-28—Hospital Association of Pennsylvania and Pennsylvania Association of Nurse Anesthetists, Bellevue-Stratford Hotel, Philadelphia.
- May 3-4—Kansas State Hospital Association, Topeka, Kan.
- May 3-5—Tri-State Hospital Assembly, Stevens Hotel, Chicago.
- May 3-5—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.
- May 8—Mississippi Hospital Association, Gulfport.
- May 15-19—American Medical Association, St. Louis.
- May 17-19—Hospital Association of New York State, Hotel Pennsylvania, New York City.
- June 8-10—New Jersey Hospital Association, Hotel Dennis, Atlantic City, N. J.
- June 18-24—American Association of Medical Social Workers, Buffalo, N. Y.
- June 22—Manitoba Hospital Association, Winnipeg, Man.
- June 25-28—American Sanatorium Association, Boston.
- July 25-Aug. 4—Southern Institute for Hospital Administrators, Duke University, Durham, N. C.
- Aug. 13-15—National Hospital Association, New York City.
- Aug. 27-Sept. 1—American Dietetic Association, Ambassador Hotel, Los Angeles.
- Sept. 11-15—American Congress on Obstetrics and Gynecology, Cleveland.
- Sept. 19-23—International Hospital Association, Toronto, Ont.
- Sept. 21-22—Canadian Hospital Council, Toronto.
- Sept. 24-25—American College of Hospital Administrators, Toronto.
- Sept. 25-29—American Hospital Association, Toronto.

Dedicates New Main Unit

The Lowell General Hospital, Lowell, Mass., recently dedicated its new main building to the memory of Frank Hanchett, a director from 1914 until the time of his death in January, 1938. The building occupies a commanding site on the hospital property at the brow of the hill. The exterior has been designed in Colonial style to conform with the hospital's other buildings. Advantage of a southern exposure has been taken to provide a wide stone-paved entrance terrace which will be bordered with flowers.

Administrative offices of the hospital are located on the first floor; the entire second floor is used for the x-ray unit and laboratories, and the third floor is assigned to the operating suite. This building is connected by underground tunnel with the other buildings and a large self-leveling service elevator is located directly opposite the tunnel entrance in the basement.

The building is of fireproof construction, with reinforced concrete floors and brick exterior walls.

Million Dollar Hospital

Two complete dental departments, six operating rooms and two emergency operating rooms and isolation sections for contagious disease patients and mental patients are among the notable features of the new million dollar Charlotte Memorial Hospital, Charlotte, N. C., on which work has started. The building will have seven stories, in addition to a ground floor and a basement. It is planned to provide room for 300 patients.

Fire at Stockton Hospital

It took every piece of fire fighting equipment in Stockton, Calif., and every available fireman, aided by police officers and 200 members of the American Legion, to put out the recent fire at the Stockton State Hospital, to round up escaped patients at the institution and to restore order. No lives were lost although 350 men housed in the building were routed. Damage was chiefly to the top floor and the attic of the southwest wing. Loss is estimated at \$35,000.

North Woods Hospital

A remote and inaccessible area in the North Woods of Minnesota will be served by the new \$60,000 municipal hospital at Warroad, Minn. The hospital will be a two story structure of reinforced concrete and, it is said, will be the only thoroughly modern hospital in that part of the state.



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Names in the News

Administrators

DR. LUNEY VARDON RAGSDALE has taken over his duties as superintendent of Butterworth Hospital, Grand Rapids, Mich. He succeeded Dr. NORBERT A. WILHELM, who has become superintendent of Peter Bent Brigham Hospital, Boston. Doctor Ragsdale, who has been assistant superintendent of Massachusetts General Hospital, Boston, received his training in hospital administration at Peter Bent Brigham Hospital, as did his predecessor at Butterworth Hospital, Doctor Wilhelm.

RUTH BEAN, Newton, Mass., has replaced LOUISE M. COLEMAN as superintendent of the House of the Good Samaritan, a hospital that cares for children with chronic heart disease. Miss Bean, who has been in charge of an outpost of the Grenfell Mission in Labrador, served overseas with the Red Cross, later becoming assistant to the dean at the school of nursing, Duke University. At later periods she was superintendent of the Biltmore Hospital, Asheville, N. C., and of the Berkeley County Hospital at Monck's Corner, S. C. Miss Coleman resigned recently after thirty-three years of service as superintendent of the House of the Good Samaritan.

GRACE E. ALLISON, for more than fourteen years superintendent of the Samaritan Hospital, Troy, N. Y., resigned her position the first of the year and has retired to private life. BEATRICE SPARGO of Dorchester, Mass., has been named to succeed Miss Allison. An executive of wide ability, Miss Allison is a former president of the Northeastern New York Hospital Association and has served as vice president of the New York State Hospital Association.

A. EDWARD A. HUDSON, administrator of the Waynesboro Community Hospital, Waynesboro, Va., has resigned that position to become administrator of El Paso Masonic Hospital, El Paso, Tex., and has taken over his new duties. Mr. Hudson served as consultant during the construction of the Waynesboro hospital and directed the purchase and installation of all equipment.

DR. D. L. HARRELL JR. has been named superintendent of the projected Petersburg State Colony, Petersburg, Va., an institution created to care for Negro feeble-minded. Doctor Harrell formerly was first assistant physician at the State College for Epileptics and Feeble-Minded at Lynchburg, Va., to which position he was succeeded by



Photograph by Bachrach

Ruth Bean was appointed superintendent of the House of the Good Samaritan, Boston, last month.

DR. J. O. HURT, former assistant physician at Western State Hospital, Staunton, Va.

DR. FLOYD K. FOLEY has taken over his new duties as superintendent of Eastern State Hospital, Lexington, Ky. He succeeds to the post vacated by Dr. J. L. VALLANDINGHAM. Doctor Foley, a psychiatrist, formerly was senior physician at the Veterans Administration Facility, Lexington.

DR. GEORGE F. ROELING has been named superintendent of New Orleans City Hospital for Mental Diseases to succeed the late Dr. L. L. CAZENAVETTE. Doctor Roeling has served as statistician and visiting neuropsychiatrist at Charity Hospital, New Orleans, for several years.

WILLIAM D. ENTLEY has been named superintendent of Arnot-Ogden Hospital, Elmira, N. Y. Mr. Entley has served as superintendent of Scranton State Hospital, Scranton, Pa., for the last ten years and has had thirty years' experience in the hospital field. He succeeds ERNEST G. MCKAY, who resigned recently.

Tribute to her twenty-five years of exceptional service as superintendent of the Charity Eye, Ear and Throat Hospital of Buffalo, N. Y., was paid CATHERINE A. KESSEL at a recent dinner in Buffalo celebrating her silver anniversary as superintendent. Present to extend congratulations were forty-three members of the hospital staff.

L. A. JOHNSON is the new superintendent of Southeast Missouri Hospital, Cape Girardeau, Mo., succeeding T. J. MCGINTY.

JOHN CRANE has accepted the superintendency of Physicians' Hospital, Jackson Heights, Flushing, N. Y. Mr. Crane formerly was superintendent of Gotham Hospital, New York.

BLANCHE STAIR is the new superintendent of Berger Hospital, Circleville, Ohio, succeeding ETHEL KIRCHOFER, resigned. Miss Stair has served as superintendent of Public Hospital, Painesville, Ohio; as superintendent of the hospital and nurses at Community Hospital, Long Beach, Calif., and as superintendent of Highland Hospital, Belvidere, Ill.

MARY E. MONGEAU has been appointed superintendent of Webster District Hospital, Webster, Mass. She formerly was superintendent of Milford Hospital, Milford, Mass.

HOWARD S. PFIRMAN has assumed his new duties as superintendent of Middlesex Hospital, Middletown, Conn. Mr. Pfirman went to Middletown from Brooklyn, N. Y., where he was assistant superintendent of Prospect Heights Hospital.

ANDREW F. O'CONNOR has been appointed acting superintendent of Arizona State Hospital, Phoenix, to succeed Dr. B. M. BERGER, who recently submitted his resignation.

CHARLES F. SARGENT is the new manager of the Veterans Administration Facility at Batavia, N. Y., replacing ARTHUR J. DALTON, who was transferred to the Veterans Administration Facility at Baltimore.

ERNEST G. MCKAY, former superintendent of Arnot-Ogden Memorial Hospital, Elmira, N. Y., will assume his new duties as superintendent of Tampa Municipal Hospital on February 1. Mr. McKay has served as superintendent of the Elmira hospital for ten years and before that was assistant administrator of Presbyterian Hospital, Chicago.

OLIVE P. MURPHY, has been named superintendent of Bartholomew County Hospital, Columbus, Ind., replacing MRS. THOMAS A. WARNER, who has resigned. Mrs. Murphy has served as superintendent of the Randolph County Hospital, Winchester, Ind., for eight years.

LUCY A. POLLOCK, superintendent of William W. Backus Hospital, Norwich, Conn., was elected president of the Connecticut Hospital Association at the annual meeting recently. Other officers named were: Wilmar M. Allen, M.D.,

LOOKING FORWARD



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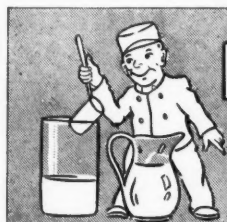
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director of Hartford Hospital, Hartford, Conn., vice president; FRED J. LOASE, superintendent of Greenwich Hospital, Greenwich, Conn., secretary, and ANNA M. GRIFFIN, superintendent of Danbury Hospital, Danbury, Conn., treasurer.

Trustees

LINCOLN CROMWELL has succeeded STEPHEN BAKER as president of the board of managers of St. Luke's Hospital, New York. Mr. Baker has been a member of the board for thirty-eight years and president since 1921. Other new officers include J. STEWART BAKER, vice president; ANDREW V. STOUT, treasurer, and ROGERS H. BACON, reelected as secretary.

Four new trustees were appointed to the board of managers of Somerset Hospital, Somerville, N. J., according to a report by DR. AUGUSTUS R. KNIGHT, president. They are ROBERT B. HESSON, former mayor of Bound Brook, N. J.; CARLE M. BIGELOW, Whitehouse Station; JOHN BEGGERT, Manville, and C. PALMER BATEMAN, Somerville.

DR. CHARLES C. FRANCIS was elected president of the medical board of the Lutheran Hospital of Manhattan at the board's recent annual meeting. Named to serve with him were DR. W. W. BOSTWICK, vice president; DR. FRANCIS MORHARD, secretary, and DR. ELMER SMITH, registrar.

Three new members were elected to the board of trustees of the Evanston Hospital Association, Evanston, Ill., recently. They are JOSEPH A. RUSHTON, elected for a one year term, and GEORGE C. WILLIAMS and EDWARD B. HALL, both of whom were elected for three year terms. ROBERT T. SHERMAN is president of the association, CHESTER A. COOK and WILLIAM H. BARNES are vice presidents; MRS. PERKINS B. BASS is secretary; WILLIAM H. DUNHAM is assistant secretary; CHARLES C. WELLS is treasurer and JOHN B. HAPP is assistant treasurer. Reelected to the board of trustees were WILLIAM H. BARNES, PAUL E. FAUST, JOHN J. LOUIS, CLINTON MERRICK, HOLMAN W. PETTIBONE, H. A. SCANDRETT, E. S. WESTBROOK and MRS. SAMUEL W. WHITE.

Department Heads

DR. MAXWELL S. FRANK has been named assistant director of Mount Sinai Hospital, New York, according to an announcement made by DR. JOSEPH TURNER, director. Doctor Frank is a graduate of New York University College of Medicine and has just completed two years' service as a resident in administration at the New York Hospital for Joint Diseases.

DR. O. M. RANDALL has been chosen chief of staff at Edward W. Sparrow Hospital, Lansing, Mich., replacing DR. O. H. BRUEGEL.

SARAH E. BENDER has been named supervisor of the pediatrics department of Robert Packer Hospital, Sayre, Pa. Miss Bender is a graduate of St. Luke's Children's Hospital and completed her graduate work at Children's Memorial Hospital, Chicago.

DR. J. D. FOUTS has been elected chief of staff of the Miami Valley Hospital, Dayton, Ohio. DR. A. T. BOWERS was named assistant chief of staff and DR. R. W. CORWIN will serve as secretary.

DORIS E. DENNIS, R.N., has been named x-ray technician at Soldiers and Sailors Memorial Hospital, Penn Yan, N. Y. She succeeds AGNES WEBB, who has taken a position as night superintendent of King's Daughters' Hospital, Martinsburg, W. Va.

JEAN TRENTHAM, director of nurses at Knoxville General Hospital, Knoxville, Tenn., and ALICE GREENWELL, instructor of science in the hospital's nursing school, have resigned as the result of protests by student nurses that their privileges were being curtailed. In a signed statement Miss Trentham said that she did not have full authority over the nursing school and could not continue under such an arrangement, a statement that was denied by TOM H. HAYNES, superintendent.

MARY B. F. WAGNER, R.N., night supervisor at Jones Eye, Ear, Nose and Throat Hospital, Johnson City, Tenn., has taken a position as chief operating room supervisor at Episcopal Eye, Ear and Throat Hospital, Washington, D. C.

DR. W. O. DAISY has been elected president of the medical staff of Peninsula General Hospital, Salisbury, Md.

Miscellaneous

DR. MALCOLM GOODRIDGE, professor of clinical medicine at Cornell University Medical School, recently was elected president of the New York Academy of Medicine, for a two year term. DR. RUFUS I. COLE was elected vice president for three years.

DR. PAUL HUSTON STEVENSON, recently returned from service in the Far East, where he was on the staff of the Peking Union Medical College, has been appointed research fellow in medical center administration and concurrently assistant to the dean at the University of Cincinnati College of Medicine and the Cincinnati General Hospital.

DR. A. E. MORGAN has been named senior physician at Eastern State Hos-

pital, Lexington, Ky., by the superintendent, FLOYD K. FOLEY.

LILLIAN H. ERICKSON, R.R.L., president of the American Association of Medical Record Librarians, has accepted a position as record librarian at St. Luke's Hospital, Chicago. Miss Erickson formerly was record librarian at Children's Hospital, Milwaukee.

SELMA LINDEM, librarian at Presbyterian Hospital, Chicago, has been given a six months' leave of absence in order to organize a new central library plan for the hospitals of New York City. The library plan will be sponsored by the New York Junior League. VIRGINIA BONNICI will be in charge of the Presbyterian Hospital library during the time Miss Lindem is in New York.

Deaths

TAYLOR STRAWN, Chicago, president of the Chicago Plan for Hospital Care, died December 24 of coronary thrombosis. Mr. Strawn was secretary-treasurer of the Chicago Hospital Council and a trustee and former president of Grant Hospital, Chicago.

DR. WILSON RUFFIN ABBOTT, trustee and chairman of the medical executive committee of Henrotin Hospital, Chicago, died recently. An authority regarding treatment of diseases of the chest and heart, Doctor Abbott was one of the first physicians to use artificial pneumothorax. He was clinical director of the Chicago Tuberculosis Institute for several years.

GEORGE F. INCH, superintendent of the Ypsilanti State Hospital, Ypsilanti, Mich., died of a heart ailment after an illness of more than two years.

F. V. LUDEKINS, for fifteen years superintendent of Homestead Hospital, Pittsburgh, died recently following a heart attack. Miss Ludekins, who as a young girl was presented to Queen Victoria, served as a nurse in South Africa during the Boer War. She formerly was superintendent of Children's Hospital, Philadelphia.

DR. J. ALLEN JACKSON, superintendent of Danville State Hospital, Danville, Pa., for eighteen years, died recently after several months' illness. Doctor Jackson was a member of the editorial board of *The Modern Hospital*.

MRS. CLARA B. HIPKE, Milwaukee, founder of the Milwaukee Maternity and Dispensary Association, died recently at her home.

SARAH PAULINE CRAWFORD, R.N., first superintendent of nurses at Macon Hospital, Macon, Ga., and later superintendent of nurses at King's Daughters' Hospital, Waycross, Ga., died recently at the age of 81 years.

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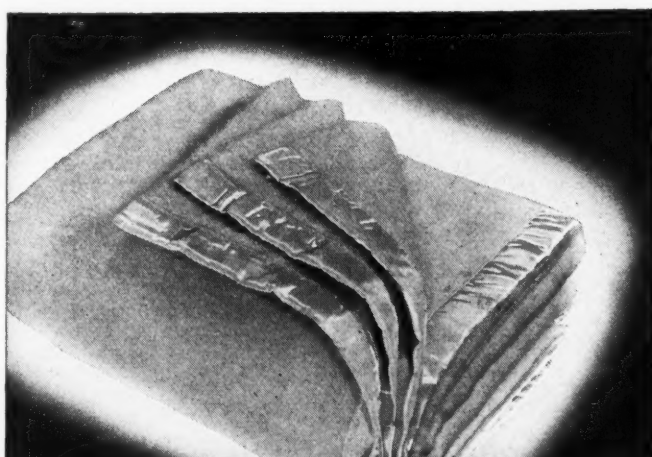
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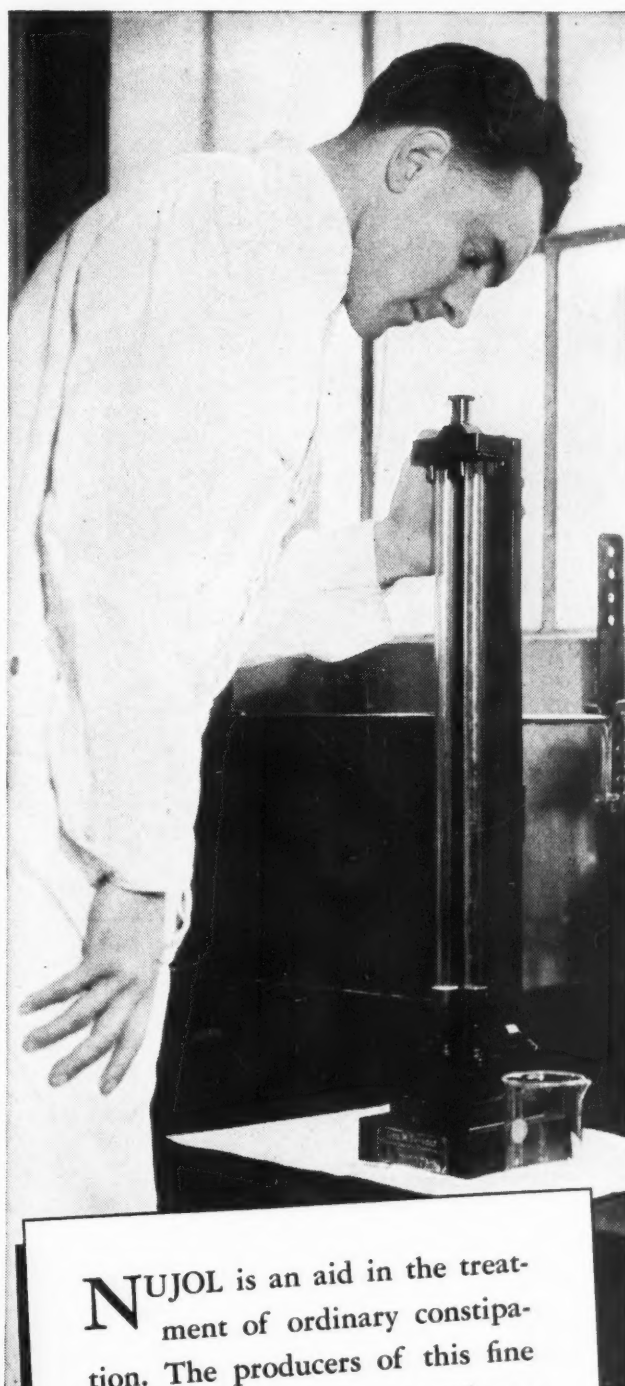
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LITERATURE *in* ABSTRACT

Conducted by E. M. Bluestone, M.D., and William B. Talbot, M.D.

Model Dental Internship

The internship in dentistry offered at the Lincoln Hospital* in New York might serve well as a model in planning the training to be given to the intern.

The prosthetic clinic meets every Thursday afternoon. An oral surgery clinic, furnished with the latest in dental equipment, meets five mornings a week. Prenatal patients are thoroughly examined by the intern and all sources of oral foci of infection are eradicated by the time the patient is admitted to the obstetric ward. The intern is intimately in contact with every patient in his daily ward examination. One intern remains on call throughout the day and night for emergency cases.

Close relationship and understanding exist between the medical intern and the dental intern in the hospital. Opportunities, which are valuable for his future practice of dentistry, are granted to the intern. He can become familiar with operating room procedures, a contact that broadens his understanding of anesthesia. He is in charge of x-ray apparatus and has access to thousands of roentgenograms on file, as well as being in charge of special case films and diagnostic records. The facilities of the bacteriologic and pathologic laboratories are at his disposal.

By carefully keeping case records and faithfully noting his observations, the intern at the termination of his internship will have acquired a tremendous amount of information for future reference.

*Cartin, Samuel, D.D.S.: A Planned Hospital Internship for the Dental Graduate, *J. Am. Dent. A. & Dent. Cos.*, October 1938. Abstracted by David Tanchester, D.D.S.

Incidence of Tonsillectomy

A major phenomenon in modern surgery is the astonishing incidence of tonsillectomy. In England 200,000 such operations are performed annually*. In the United States one-third of the number of operations performed under general anesthesia are tonsillectomies.

For many years after the introduction of anesthesia and aseptic surgery the incidence of this operation remained low. In the early part of the twentieth century there was a rapid rise, which continued until 1931, when there was a sharp fall. In 1936 the

curve began upward again. The incidence is higher in boys than in girls; the highest age incidence is from 5 to 7 years. The age factor suggests that the indications for operation may be stimulated by purely physiologic and immunologic enlargements; the present age distribution is probably too young to obtain the best possible results.

Large reductions in the numbers of operations performed in elementary school children in certain areas have had no unsatisfactory results. Tonsillectomy is three times as common in the children of well-to-do classes, possibly a manifestation of parental anxiety. The mortality rate from the operation is higher than is generally appreciated.

A study of the facts seems to indicate that tonsillectomies are performed indiscriminately as a routine prophylactic ritual for no particular reason and with no particular result.

*Glover, J. Alison, M.D.: The Incidence of Tonsillectomy in School Children, *Proceedings of the Royal Society of Medicine, Section of Epidemiology and State Medicine*, May 27, 1938. Abstracted by J. Masur, M.D.

Invisible Panel Heating

This system of heating* is used primarily in public buildings. While several large installations have been made in Europe, it has been introduced in this country only recently.

The important feature of this heating system is the fact that the heat is transferred in a manner similar to the heat radiated by the sun. The heating coils are embedded in the concrete on the underpart of the floor or are hung in the ceiling between the underpart of the floor and furred ceiling. Hot water, generally used as a heating agent, is forced through the coils, which are made in one continuous piece, running the length of the floor in hairpin fashion, radiating the heat directly from the ceiling toward the floor. There are several types of construction that can be used in conjunction with this heating method.

After the installation has been made and heat is radiated through the lower portion of the floor or the ceiling into the room, it causes convection of heat set up by surfaces, such as fabrics, furniture, and the like, that are warmed by the direct radiation from the ceiling.

As floor or wall radiators are not used in this system, painted surfaces

are not soiled, owing to the fact that in the old type of system the cold air is drawn under part of the radiator and the hot air rises from the radiator, carrying with it particles of dirt and dust that are deposited on walls. The space formerly occupied by radiators can be utilized for other purposes. The direct drafts are less effective because the concentration of heat directly radiating from the ceiling does not allow the room to cool off as rapidly as it does when floor or wall type radiators are used for heating.

With the panel system of heating, a study of decorating should be considered. Varnish and oil enamels are not suitable because of their glossy finish.

There are no data available as to the maintenance cost. It is obvious, should one of the coils commence to leak, that it would necessitate opening a portion of the ceiling on the underpart of the floor to make repairs, which would appear to be somewhat expensive.

*Unsigned: Invisible Panel Warming, The Invisible Panel Warming Association, London. Abstracted by William J. Overton.

Handling Dietary Personnel

One of the important problems of the dietitian is to fit the operation of her department to her budget and to maintain a stable working force. The author* stresses the importance of job analysis. The person should be suited to the job and, if not, a transfer should be made to try to find the best job for the employee. There should be a logical sequence to the jobs and the workers should be given a chance to study the job just ahead of them so they may step into it if the occasion arises.

In employing new workers, an application blank should be filled out preceding the personal interview. The new employee should be given a job analysis, as well as a list of rules and regulations so he may know what is expected of him. This is most important as the labor turnover is highest among new employees.

Instructions must be given to prevent accidents and to keep a high standard of cleanliness. Health of the employee is important.

"With regard to wages it is better to have a small number of good employees, well paid, than a greater number of poor ones, poorly paid." Wages, in the end, are the employees' chief objective. It is best to pay once a week and, if checks are given, a means of cashing them easily should be provided.

*Carpenter, Ruth H.: Personnel Management in the Dietary Department, *J. Am. Dietet. A.*, May 1938. Abstracted by Margaret Carter.